University of Alberta

An Exploration of the Scope of Practice of Registered Nurses Providing Primary Health Care Services in a Community Based Setting

by

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©

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Abstract

Primary health care (PHC) provides nurses with an unparalleled opportunity to expand their practice. In 1985, the W.H.O. acknowledged nursing's pivotal role, noting that the practice of nurses would undergo a significant change as the focus of health care moved away from the medical model. Yet since then, there have been few conceptual constructs created to reflect the changes to nursing practice.

Designed as an instrumental case study, this pilot study explored the current practice of registered nurse for nurses providing PHC services in Alberta as well as the barriers and facilitators to working to full scope of practice. Nurses, physicians and managers working in two community-based health care services participated in the research.

The perceptions of the three groups support the premise of the Conceptual Framework concerning factors important to scope of nursing practice: Clients, Practice Setting, Employer Requirements, RN Attributes and Scope of Practice.

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While the name of only one individual appears on a Master's thesis, many more people have played significant roles by supporting the researcher and by participating in the research itself. I would like to thank everyone who has so kindly given their time and support over the past few years.

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CHAPTER I
INTRODUCTION AND LITERATURE REVIEW

In this chapter, the literature on the scope of practice for registered nurses working in primary health care settings is explored. A conceptual framework for the scope of practice, developed by the principal investigator, is presented. The purpose of the research study is introduced along with the research objectives and questions.

Significance of the Study

Primary health care has emerged as one of the dominant themes shaping the health care system of the future. In September 2000, Canada's federal, provincial and territorial ministers of health issued a joint communiqué that stated "improvements to primary health care are crucial to the renewal of health services. Governments are committed to ensuring that Canadians receive the most appropriate care, by the most appropriate providers, in the most appropriate settings."(Canadian Intergovernmental Conference Secretariat, 2000). Earlier that year, the federal government established a four-year, $800 million fund for primary health care reform projects. Following that agreement, the federal Minister of Health announced that Alberta would be given an additional $54 million for expansion of primary health care pilot projects (Health Canada, 2001).

Released in the fall of 2001, the Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology, noted that the "need for significant changes to the way primary health care is delivered has been the principal thrust of the recommendations of a number of provincial health care reviews, notably the Sinclair Commission Report in Ontario, the Clair Commission Report on health care delivery in

Quebec and the Fyke Report on health care delivery in Saskatchewan" (Kirby, 2001, p. 28).

The shift to a PHC framework obviously presents the health care sector with great opportunities and challenges as it moves away from the medical model embedded in the Canada Health Act. Canada's Senate Commission has acknowledged "the way in which health care is now delivered in Canada does not normally reflect a PHC philosophy..."(Kirby, 2001, p. 111). Despite Canada's support of primary health care, legislative, policy, funding and attitudinal barriers have interfered with its implementation (AARN, 1998). Legislative barriers include the restriction of the Canada Health Act to physician and hospital-based services as well as provincial legislation that prevents professionals from working to their full scope of practice. Policy and funding barriers are linked with legislative barriers and include the government's focus on acute care as the top funding priority for health care and institutional policies that "restrict activities of health care providers to meet organizational requirements rather than client needs" (AARN, 1998, p. 8-9). The AARN describes attitudinal barriers as the "most potent of barriers because, as reflections of cultural values and beliefs, they lead to the codifying of these values as legislation, regulations, and policies" (AARN, 1998, p. 9).

Primary Health Care

Primary health care moved to the forefront of the international health policy agenda in the late 1970s. At the Alma Ata conference in 1978, 134 countries endorsed the World Health Organization's (WHO) definition of primary health care as "...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community

through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process" (WHO, 1978, p. 429).

Primary health care is a clear departure from the western scientific medical model of health care (Dykeman & Ervin, 1993; van Maanen, 1990; Schoenhofer, 1995), which focused on the curative treatment of individuals. Primary health care "forms an integral part both of the country's health system, of which it is the nucleus, and of the overall social and economic development of the community. It addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly" (WHO/UNICEF in Pullen et al., 1994, p. 201).

Confusion over the philosophic underpinnings of primary health care has been evident since the Alma Ata conference (WHO, 1985; MacIntosh & McCormack, 1995; Dykeman & Ervin, 1993; Lauzon, 1993; Shoultz & Hatcher, 1997). In fact, Dykeman and Ervin (1993) have suggested that the development of a true primary health care system has been hindered by an emphasis on delivering the medical model of health care via community-based services. Even today, the term 'primary care' is used interchangeably with primary health care by the health care policy community (most recently in Kirby, 2001; Fyke, 2000; Marion, 1996) despite definitions that clearly distinguish between the

two concepts. Primary care is a "medical model of care" (Lauzon, 1993, p. 18) with the "delivery of a complex set of services, which includes the first contact and the maintenance care" (Barnes et al., 1995, p. 8). It is "commonly thought of as front-line medicine. Essentially, it denotes first contact by physicians and their control of patient entry to insured services" (Innes, J., 1987, p. 17-18). In comparison, primary health care is based on the five principles of accessibility, public participation, emphasis on prevention and promotion, appropriate technology and intersectoral cooperation. While primary care services are part of primary health care, primary health care "through the collaboration of health professionals, community members, and others working in multiple sectors, emphasizes health promotion, development of healthy policies, and prevention of diseases for all people" (Shoultz & Hatcher, 1997, p. 24). Primary health services "are the foundation of a system that promotes and maintains health as well as providing everyday health care to all..." (Fyke, 2001, p. 5).

Registered Nurses and Primary Health Care

Government reports have recognized that scopes of practice play a crucial role in the success of planned changes to the health care system (Kirby, 2001; Fyke, 2001; Backman, 2000). Since nearly 70% of the current health care budget is spent on human resources based on an illness-based medical model, the "implementation of a new Primary Health Service model will require the re-deployment and reorganization of existing staff" (Fyke, 2001, p. 63).

In 1985, the WHO's executive board officially endorsed the nursing profession's key role in the development of primary health care through its "health for all" project (WHO, 1985). The WHO stated "The role of nurses will change as more of them will

move from the hospital to the everyday life in the community, where they are badly needed… Nurses will become resources to people rather than resources to physicians, they will become more active in educating people on health matters…Nurses will participate more actively in inter-professional and inter-sectorial [sic] teams for health development" (WHO in van Maanen, 1990, p. 922).

The Canadian Nurses Association (CNA), which represents the largest group of health professionals in Canada, has also been a major proponent of the concept of primary health care. According to the CNA, the nursing profession is "ideally positioned, at the heart of the health care system, to help Canadians make the change to a PHC philosophy" (CNA, 1993, p. 10). Modern nursing has its roots in a primary health care approach beginning with Florence Nightingale's initiatives to improve community health in the Scutari camps by addressing the determinants of health and Lillian Wald's efforts to provide public health nursing in the United States. In fact, "every Canadian jurisdiction that defines nursing in its professional legislation now explicitly includes at least one and sometimes a combination of the functions of promoting health, maintaining health and preventing disease in the scope of practice" (CNA, 1993, p. 25). However, the CNA has noted that "new definitions of health roles, new modalities of health-care delivery and upgrading of education systems for health professionals will be necessary for the shift in orientation to health and health promotion" (CNA, 1993, p. 25).

A review of the literature suggests that despite the passage of more than two decades since the Alma Ata declaration and the support of the CNA for registered nurses playing a key role in primary health care, there have been minimal conceptual constructs created to reflect changes to nursing practice in primary health care (Besner, 2000;

Munro et. al, 2000). Much of the North American literature surrounding primary health care provides anecdotal descriptions of new health care centers that strive to adopt a primary health care approach (Attridge et al, 1993; Clear, 1999; Hatcher et al., 1998; Gerrity, 1999). Research in the United Kingdom, which has incorporated primary health care into its National Health Service, reported in 1986 that "many primary health care teams existed in name only and focused more on crisis intervention during episodes of sickness than prevention and health promotion" (Poulton & West, 1993, p. 919). Since that time, the interdisciplinary teamwork required in primary health care has received a greater degree of attention from researchers (Jenkins-Clarke, 1998; Galvin et al, 1999; Pringle et al, 2000). Reports from the National Health Service have suggested that there is confusion amongst health professionals regarding the roles and functions of the various team members and that role clarity is required for the appropriate functioning of the primary health care team (DHSS, 1986; Audit Commission, 1992).

Currently, the roles of registered nurses in primary health care have been variously described as: direct care provider, teacher/educator/resource, supervisor/manager/team leader, researcher/evaluator, experts, facilitator/mediator, consultant, catalyst, negotiator, public health care crusader, collaborator, organizer and planner (Lauzon, 1993; Barnes et al, 1995; Bless et al, 1995). Attributes of registered nurses necessary for their roles include "accountability, courage and self-confidence, sharing, self-analysis, mentoring, innovation and vision, cultural sensitivity, high level of objectivity, flexibility, realism, caring, personal conviction, love of learning and enhancing advocate development" (Bless et al, 1995, p. 76).

Articles providing commentary on PHC suggest that nursing practice will be impacted as the "professional is no longer the accepted leader in providing care for the individual but is a partner with the client" (Stachtchenko & Jenicek in Dykeman & Ervin, 1993, p. 1567). Nurses must adapt to client/community empowerment by acting "in a nurturing, facilitating role as opposed to 'doing for' clients. In working toward this goal, PHNs must accept new ways of relating to and being a resource for the public" (Beddome et al, 1993, p. 17). Martens suggests that nurses who practise within PHC "are challenged by its epidemiological approach, its emphasis on community advocacy and participation, and the enlarged parameters within which it defines and delivers health" (1993, p. 12). Nurses who received their nursing education under the medical model must develop new skills to practice under the PHC philosophy. New models of nursing practice, with a greater focus on the principles of primary health care are beginning to emerge.

In Canada, the McGill Model (which focuses on the family aspect of primary health care) and the Prince Edward Island Conceptual Model have been developed over the last few years. The PEI model, which was proposed as a model to guide the university education of registered nurses, provides suggestions for best practice applications of PHC. However, while a study involving the PEI model has been commissioned by the Canadian Health Services Research Fund, no findings have been published. Further details of both of these nursing models is contained in Appendix I. Although both of these models have been applied to PHC settings, the models focus on the delivery of nursing care and the relationship between the nurse and client. Since the models do not

include other factors which influence the broader scope of nursing practice such as employer requirements, the models were not examined through this research study.

Scope of Practice

The scope of practice for any profession "encompasses the activities its practitioners are educated and authorized to perform…[it] sets the outer limits of practice for all practitioners" (CNA, 1993, p. 3). It is "both a legal and a professional definition" (Northrop, p. 104). The legal scope which is "found in the …[provincial] nursing practice act… and accompanying regulations, describes the parameters of nursing practice" (Northrop, p. 104). The profession's scope of practice is "the base from which governing bodies prepare standards of practice, educational institutions prepare curricula, and employers prepare job descriptions" (CNA, 1993, p. 3).

The Canadian Nurses Association also distinguishes between the profession's scope of practice and an individual registered nurse's scope of practice. According to the national association representing nursing licensing bodies across Canada, the actual individual scope of practice is "influenced by the settings in which they practice, the requirements of the employer and the needs of their patients or clients" (CNA, 1993, p. 3).

In Canada, each provincial government has described the legal scope of practice in legislation. Professional licensing bodies are then charged with the legislated responsibility for ensuring "that safe, competent and ethical nursing care is provided to society" by registered nurses (AARN, 1992, p. 1). Alberta's Nursing Profession Act describes the legal parameters of practice for registered nurses as the application of:

professional nursing knowledge for the purpose of

(a) promoting, maintaining or restoring health;

(b) preventing illness, injury or disability;

(c) caring for the injured, disabled or incapacitated;

(d) assisting in childbirth;

(e) teaching nursing theory or practice;

(f) caring for the dying;

(g) co-ordinating health care;

(h) engaging in the administration, education, teaching or research required to implement or complement exclusive nursing practice or all or any of the matters referred to in clauses (a) to (g).

(Province of Alberta, 1983, s. 1(2))

In its policy document, *Scope of Nursing Practice,* the AARN has defined nursing's scope of practice as encompassing the legislated definition of nursing, nursing education preparation and the nursing practice continuum, along with the roles and activities of registered nurses (AARN, 1992, re-endorsed 2000). In Alberta, educational preparation of nurses ranges from those who have graduated from a diploma program to those holding doctoral degrees. The nursing practice continuum includes those nurses who have recently graduated and who are providing basic nursing services to those who have obtained "additional education, experience and highly specialized skills [to] provide care in complex clinical situations, manage health promotion programs in the community, [and/or] develop healthy public policy…" (AARN, 1992, p. 3). Each nurse would occupy her own position on the continuum based on her "preparation and competency…, characteristics of the practice setting and the requirements of the client for care" (AARN, 1992, p. 3). Roles for registered nurses in any practice setting could include: "caregiver,

teacher, client advocate, counsellor, coordinator, researcher, consultant, community developer, health care manager, facilitator, resource manager/planner and/or policy developer" (AARN, 1992, p. 3).

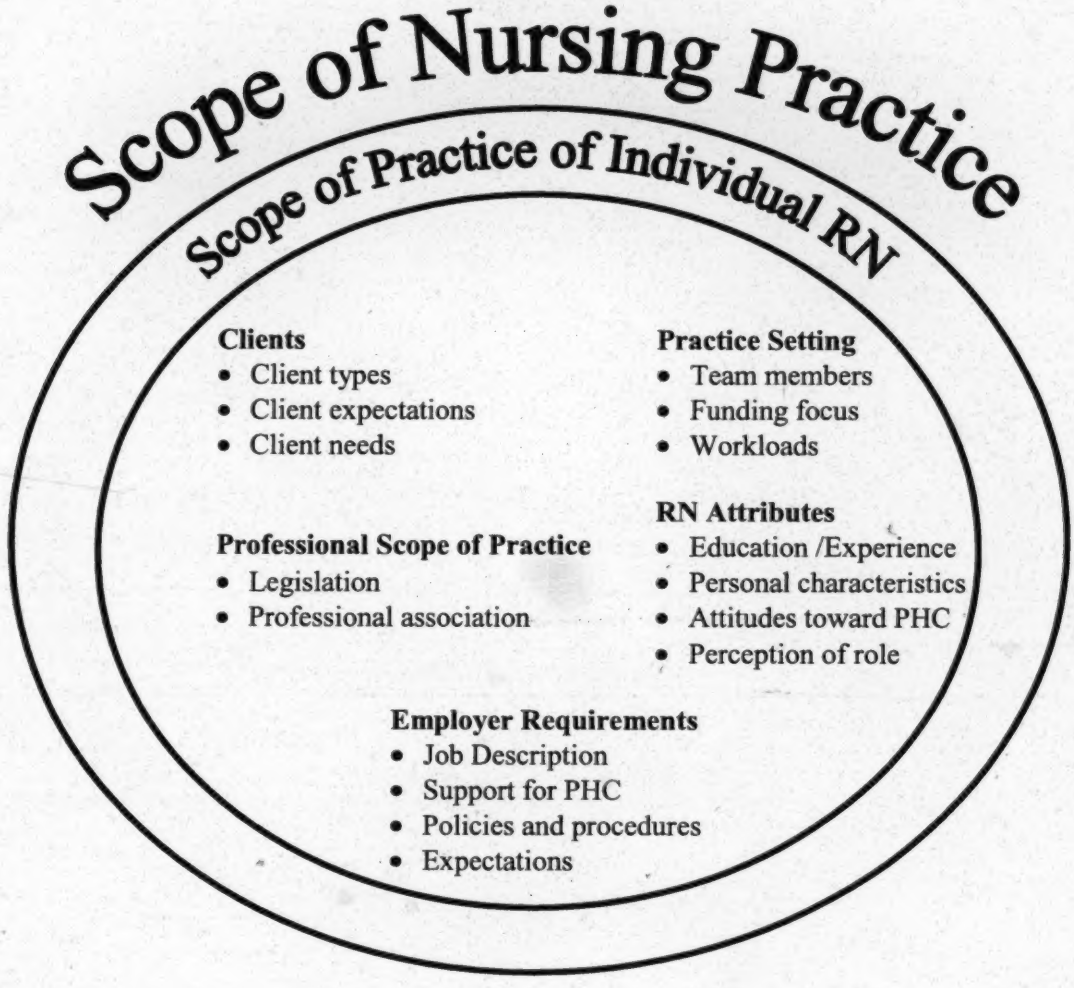
Over the last few years, several provincial nursing associations have advocated for a greater scope of practice for registered nurses through either expansion or extension of nursing practice. Those efforts have been primarily focused on the extension of scope of practice to allow nurses to perform activities "that were previously undertaken by medical doctors, or other healthcare professionals" (Davis, 1992 in Magennis, 1999, p. 2). In Alberta, the AARN successfully lobbied for legislation for an extended nurse practice register. Receiving less attention has been the expansion of the nursing roles to include practice that is already "within the boundaries of nurse education, theory and practice" (Davis, 1992 in Magennis, 1999, p. 2). [An example of extended practice activities would be the prescribing of drugs by registered nurses; expanded practice activities would include lobbying for improved housing or water quality.] While the scope of practice has been the subject of policy documents and descriptive articles, there is an absence of empirical research.

Conceptual Framework

The literature suggests that there are a number of factors that impact on the scope of practice of individual registered nurses. However, while the factors have been listed in policy papers, there is limited information available regarding the extent to which, or how, these scope of practice factors actually affect the practice of nurses, particularly in primary health care.

The conceptual model proposed herein attempts to build upon the current literature's inventory of factors to describe how they enhance or limit the scope of practice. It is suggested in this model that personal characteristics of the RN, the practice setting, employer requirements, scope of practice, and client attributes contribute to the boundaries of practice established for RNs. Initially, the placement in the model of the legal scope of practice presented a complication as, from a legal perspective, nurses must not exceed their broad scope of practice. A decision was made to adopt the position of the provincial professional association that governs the practice of the nurses involved in the research that the legislated scope of practice is but one component of nursing's scope of practice; thus, it is placed within the circle. The diagram of the Scope of Nursing Practice Conceptual Model is found in Figure 1.1.

Figure 1.1 Scope of Nursing Practice Conceptual Model. The five factors of the Conceptual Model include clients, RN attributes, employer requirements, the practice setting and the professional scope of practice. Each factor is associated with a number of elements.



No one factor has been given a larger portion within the circle since there is no literature suggesting that any one factor is of greater import than others. Since there is nothing in the literature describing whether the factors interact with one another, each component is considered separately.

This model proposes that the scope of practice of registered nurses will expand or contract depending upon the factors contained within the circle. For example, a nurse with a knowledge base developed through years of experience is presumed more likely to have a greater scope of practice than a nurse with only 2-3 years of experience. However, the model recognizes that if the employer of the more experienced nurse restricts her practice with a narrow job description, that nurse may actually have a narrower scope of practice.

In the middle of the diagram, a circle surrounded by the words 'registered nurse practice' appears. Inside the circle are the names of the various factors that constrain or enhance the practice of the RN. A larger circle entitled "Scope of Practice" then encompasses the smaller circle. The diagram thus looks like a bulls-eye with the idea that the centre circle expands or contracts depending upon the various factors.

Contained in the model are the following elements derived from the literature:

- Attributes of RN (e.g. education, experience, attitudes toward PHC, perception of nursing role, personal characteristics)
- Practice setting (e.g. makeup of health care team, workload, funding focus)

- Employer requirements (e.g. job descriptions, policies and procedures support for primary health care practice, expectations for registered nurses)
- Scope of practice (e.g. legislation, professional association)
- Clients (e.g. client types, client expectations, client needs)

Using this conceptual framework, the research focused on the basic building blocks for an understanding of the scope of practice of registered nurses providing primary health care services in an emerging community-based environment.

Purpose of Research Study

The purpose of this study is to gather information about the scope of practice for registered nurses providing primary health care in a community-based health care service.

Research Objectives

- To compare the practice and roles of registered nurses providing primary health care in community-based health care services with their scope of practice.
- To identify challenges/barriers to registered nurses working to their full scope of practice.

Research Questions

- What is the current scope of practice for registered nurses as it applies to primary health care?
- What are the facilitators and barriers to registered nurses working to their full scope of practice within an evolving primary health care practice setting?

Organization of Thesis

The methodology used in this research project is described in Chapter 2. The findings of the study are presented in Chapter 3. Chapter 4 contains analysis and discussion of the findings along with recommendations for future research and implications for policymakers.

CHAPTER II
METHODOLOGY

General Research Approach

A lack of empirical research examining the scope of practice of registered nurses was identified in Chapter 1. The research provides information to the nursing profession and policy makers about the current scope of practice of registered nurses providing primary health care services including insight into those factors which impact upon the scope of practice. A few policy papers have suggested various factors that are believed to have an impact on scope of practice. The exploratory nature of this pilot study is appropriate since current literature reveals a lack of research reported about the scope of practice of registered nurses, particularly those working in community-based health care.

In Canada, several high-profile Commissions and Reports have recommended that increased primary health care services must play a major role in resolving the "crisis" in health care. However, little is known about the roles, activities and tasks of health care professionals providing those services. Reports from the United Kingdom suggest that the functioning of the health care team has been compromised by a lack of clarity regarding professions and their roles and abilities. It is intended that this study will lead to further study of this area.

The research questions outlined in Chapter 1 are purposely broad so as to "gain a 'holistic' (systemic, encompassing, integrated) overview of the context under study: its logic, its arrangements" (Miles & Huberman, 1994, p. 6).

This research study employed case study methodology. Case studies allow the researcher to examine the "motive, perceptions and assumptions of individuals and

groups, [and] the dynamics and processes of complex human organizations and institutions" (Boulton & Fitzpatrick, 1997). In this instance, the researchers are interested in gathering information about a complex phenomenon – the scope of practice – and what stakeholders believe to be the factors affecting that phenomenon. Case studies can include interviews and surveys as data collection techniques and are frequently used in exploratory studies.

An instrumental case study method was used for this particular research project. In an instrumental case study, the actual case is used as a "vehicle to better understand the issue" (Cresswell, 1998, p. 250); in this case, the practice experience of the registered nurses working at two pilot primary health care project sites in a large regional health authority will be the vehicle to understanding the issues surrounding scope of practice for nurses working in primary health care.

This research project was conducted as a pilot study which will allow the researchers to "develop relevant lines of questions – possibly even providing some conceptual clarification for the research design" (Yin, 1994, p. 74). The research questions had not been tested in a prior study.

Sampling Technique

Convenience sampling is useful for "exploratory research, to get a feel for 'what's going on out there'" (Bernard, 2000, p. 178). This method is often used for pilot studies, was selected as the most appropriate approach. Convenience sampling "relies on available subjects for inclusion in a sample" (Shi, 1997, p. 237). In this instance, the study population was relatively small with clear boundaries. Convenience sampling

allowed the researcher to approach the maximum number of people available from the study population.

The research was conducted at two primary health care pilot projects within a large urban regional health authority. Both were well-defined entities with clearly defined populations. The population from which the sample was drawn includes all the registered nurses, physicians, and managers at the two project sites. Site A is a health care centre providing urgent care, public health, home care and mental health services located in the downtown area. Site B is a multi-location program that provides health care education and support for individuals dealing with chronic health problems such as diabetes and dyslipidemia. The regional health authority facilitated identification of and access to staff, physicians and management of the projects. The primary investigator was responsible for recruiting subjects and obtaining consent prior to conducting document reviews, surveys or interviews.

Data gathering

Development of research instruments

Surveys and interviews that were the data collection instruments in this study were designed to gather data about the two research questions identified in Chapter 1. Separate surveys and interview guides were developed for the three groups involved in the study: registered nurses, their managers and physicians. Physicians were included in the study for two reasons: they were the only health care workers who worked closely with registered nurses in both of the project sites and because the physician scope of practice and the registered nurse scope of practice often include many of the same activities and roles.

Three survey instruments were developed for this pilot study. Three stakeholder groups, nurses, managers of nurses, and physicians, completed questionnaires and semi-structured interviews at both project sites.

The reading levels of each of the information tools were checked using the Flesch-Kincaid formula contained in Microsoft Word. The questionnaires varied between Grade 5.5 to Grade 6.6 on the Flesch-Kincaid scale.

Respondents were asked to answer closed-ended survey questions on a six-point Likert scale. The conceptual framework was used to create the questions about the factors influencing nursing practice:

- Registered nurse attributes (personal characteristics, nursing education, nursing experience and perception of their nursing role)
- Clients (types of clients, client needs and client expectations)
- Scope of practice (professional legislation, support of professional association)
- Employer requirements (job description, employer policies, employer expectations and employer support)
- Practice setting (workload, program funding, make-up of the health care team)

In addition, the survey asked closed-ended questions about the current activities and roles of the registered nurses.

Interview guides were also developed for those respondents who agreed to be interviewed. The guides, which were individualized for each of the three respondent groups, included open-ended questions about the roles of RNs working at the applicable

site. The challenges facing nurses in practicing nursing in each of the two primary health care settings were also the subject of questions.

Distribution of research instruments

A recruitment poster was developed to provide information about the research study (Appendix A). Packages were prepared for the sample population and included an information letter (Appendix B), consent form (Appendix C), agreement to interview form (Appendix D) and the survey (Appendix E). Flesch-Kincaid tests found that the recruitment poster was at a Grade 12 reading level, the information letter was at Grade 8 and the consent form was evaluated as Grade 8.6.

The recruitment poster was distributed by the managers and was posted on the staff bulletin board in Site A.

The registered nurses at the two project sites were informed of the study through presentations by the researcher at two regularly scheduled staff meetings. Packages were distributed at the meetings; staff that did not attend the meetings received the package through the staff mail system.

The Director of Research for the Region informed the managers of the study. The researcher also provided information to the managers.

Many of the physicians had practice offices outside of the project sites. Information packages were distributed through the staff mail system of Site A or were dropped off at the physician's practice office by the researcher.

Data Collection

Participants were asked to return their surveys along with the consent form and interview agreement form in stamped addressed envelopes provided in the research

package. The interview agreement form asked the subjects to indicate whether they wished to be interviewed by telephone or in-person and requested the identification of a preferred time and date for the interview. Six respondents requested in-person interviews; the remainder of the interviews (N=34) were conducted via telephone. Interviews were conducted at the preferred time and date indicated by the participants who also determined their preferred location for the interview. As a result, nearly one-quarter (23.4%) of the members of the stakeholder groups were interviewed for this pilot study.

All interview subjects agreed to allow audio-taping for the purpose of accurate transcription. Interviews ranged in length from 15 to 60 minutes depending on subject willingness to continue the interview.

Data Management

Data Entry and Transcription

Interviews were transcribed by the researcher. Questionnaire data was coded and entered into SPSS software by the researcher. Transcripts and survey results were stored electronically on the primary investigator's personal computer and archived on CD-ROM.

Accuracy of data entry was ensured by double-checking of data coding at the end of the research project.

Triangulation of the results was provided by the varied data collection methods (Cresswell, 1998). While member checking can be used to validate the data gathered in the interviews, other surveys performed with this population have suggested that time constraints inhibited participation in those surveys. As a result, member checking was not used for this research.

Content Analysis

Due to the small sample size, non-parametric tests were not conducted on the survey results. Survey data was analyzed for frequency, mean, median and mode. In order to enhance the readability of the findings, only the frequency of answers is reported in Chapter 3 (Pilot Study Findings). Appropriate tables and figures are also presented in Chapter 3.

Techniques standard for case studies were used including case description, topic identification and categorization, development of generalizations, and presentation of data and findings in narrative form. The researcher and the thesis supervisor met to review the coding framework and content analysis prior to and while analysis was in progress to ensure that interpretation of data was methodologically sound, accurate and complete. Coding categories for the interviews were developed to align with the elements of conceptual framework. The data analysis from interviews was completed by hand analysis of text for identification of themes – both those that relate to the conceptual framework proposed for this study as well as those that do not.

Research Report

The final report is published in the form of a Master's thesis. It describes the case, the research and its findings, as well as thematic analysis and naturalistic generalizations, which can be used as practical lessons for policy development. The final thesis contains "lessons learned for … research-design" (Yin, 1994, p. 76). Conclusions regarding the findings are also included.

Ethical considerations

No individual benefits for the participants were identified. No individual risks were discovered for the participants. The subjects were advised at the beginning and at various points throughout the interview process that they had the right to discontinue their participation at any time during the study.

Participation in the study was voluntary and by consent; participants were notified of their right to withdraw at any point during the study without providing a reason. All transcripts and surveys were password-protected and shared only with Dr. John Church, thesis supervisor. Transcripts and surveys were not faxed, e-mailed or communicated in such manner that could have resulted in the transcript being viewed by another person. Names were removed from all identifying information. This thesis was drafted in such a way that the identity of the subjects cannot be inferred. It is always possible, in particular with interviews, that a subject may be identified through direct quotation; to minimize that risk, all references to the particular setting, model and profession were removed from the quotations used in the research report.

Participants were advised that all information would be treated as confidential unless disclosure was required under professional codes of ethics or legislation. The data is stored in a locked filing cabinet for a minimum of seven (7) years as per the requirements of the University of Alberta. The primary investigator and the co-applicant have sole access to that data.

Ethics Approval

Ethics approval for the research was obtained from the Health Ethics Research Board of the University of Alberta in June 2003. The regional health authority where the

research was conducted accepted this approval. Additional ethics approval would be required in order to use the data for secondary analysis.

CHAPTER III
PILOT STUDY FINDINGS

The results of the pilot study are presented in this chapter. A description of the sample characteristics, including the response rate, is provided. The Chapter details the current scope of practice for RNs providing primary health care services. Findings related to the facilitators and barriers to the scope of practice are identified.

In order to reduce the data, strongly agree and agree responses, and strongly disagree and disagree answers, have been combined in the presentation of findings. Unless otherwise noted, percent values have been used; valid percent has been used where more than 10% of subjects did not respond to the question. Where respondents indicated more than one answer for questions requiring one response only, the most neutral answer was entered into the database. The text of the three survey instruments can be found in Appendix E and the three interview guides can be found in Appendix F.

Sample characteristics

Survey response rate

The sites involved in this study are pilot primary health care sites for the regional health authority; as a result, the staff, managers and physicians have been the subjects of several research projects. The low response rate for this survey could be related to research exhaustion. In addition, the response rate of physicians may have been affected by ongoing negotiations regarding payment for extra duties at one site.

Due to the small size of the sample, the findings are not considered statistically significant. A summary of the rates of participation in the survey is found in Table 3.1.

Table 3.1

Survey Response Rates From the Stakeholder Groups

Stakeholder Group	Site A			Site B			Total		
	N	n	%	N	n	%	N	n	%
RNs	56	19	34	11	8	73	67	27	40
Managers	4	3	75	5	4	80	9	7	78
Physicians	25	2	8	44	14	32	69	16	23

Interview response rate

All respondents who indicated a willingness to be interviewed were contacted. One individual indicated a willingness to participate in the interview but did not respond to three contacts to establish a time and date for the interview. Since the research project was conducted over the summer months, interviews were held over a four-month period to maximize the number of interviewees. Table 3.2 summarizes the rates of participation in interviews.

Table 3.2

Interview Response Rates From the Stakeholder Groups

Stakeholder Group	Site A			Site B			Total		
	N	n	%	N	n	%	N	n	%
RNs	56	12	21.4	11	7	63.6	67	19	28.4
Managers	4	2	50.0	5	4	80.0	9	7	77.8
Physicians	25	1	4.0	44	7	15.9	69	8	11.6

Respondent demographics

In order to protect the confidentiality of respondents, the results are reported as an aggregate of all three professional groups. Slightly more than half of the respondents indicated that they had more than five years of community experience with nearly one-

quarter (n=13) indicating they had 16 or more years of experience in a community-based setting. No survey respondents had worked in the community for less than one year.

Table 3.3

Number of Years Worked in Community-based Care

Stakeholder Groups	1-3 Years		3-5 Years		5-10 Years		10-15 Years		16 years or more	
All respondents (N =48)	n	%	n	%	n	%	n	%	n	%
	7	14.6	5	10.4	14	29.2	9	18.8	13	27.1

A slight majority of subjects (n=25) indicated that they had worked at their current site for less than 1 year. Just under one-third stated that they had worked at their current site for more than 2 years. These findings reflect the limited time that Site B had been operating when the study was conducted.

Table 3.4

Number of Months Worked at Project Site

Stakeholder Group	0-12 Months		12-24 Months		>24 Months	
	n	%	n	%	n	%
All Respondents (N=47)	25	54.3	7	15.2	14	30.4

Registered Nurses: Additional Demographics

Additional demographic information was gathered from the registered nurses since the scope of practice of registered nurses was the subject of this research project. All of the RNs (n=27) graduated from their basic nursing program between 1960 and 1997. The majority of the nurses (n=17) graduated from a diploma program; the remainder graduated with a degree.

Table 3.5

Basic Nursing Program: Diploma vs. Degree

Stakeholder Group	Diploma		Degree	
	n	%	n	%
Registered Nurses (N=27)	17	63	10	37

The nurses were asked to indicate whether they had spent clinical time in the community setting during their basic nursing program; those who indicated yes, then placed a checkmark representing the amount of time spent. While the majority of nurses (n=20) reported that they had spent clinical time in a community setting, only nine reported spending more than four weeks in the community. Degree educated nurses were the most likely to have had more than 8 weeks (n=5).

Table 3.6

Number of Weeks of Clinical Training in Community Setting in Basic Nursing Program

	<1 week		1-2 weeks		2-4 weeks		4-8 weeks		>8 weeks	
All RN	n	%	n	%	n	%	n	%	n	%
Respondents (N=17)	3	12.5	3	12.5	2	8.3	2	8.3	7	29.2

The questionnaire also explored whether nurses had received any education about community-based or primary health care related subjects during their nursing education. The areas of education were listed and respondents could choose more than one response. It was assumed that no checkmark meant that no education had been received in that area. Three-quarters (n=21) of the registered nurses reported receiving education about primary health care principles at some point during their nursing education. Nurses were nearly as likely (n=19) to have had public health nursing included in their nursing education. The

respondents were least likely to have had information about health policy mechanisms (n=7) and health services administration (n=4).

Table 3.7

Nursing Education Areas Since Basic Training

Topic	Yes	
	n	%
Primary health care principles	21	77.8
Public health nursing	19	70.4
Community advocacy	14	51.9
Epidemiology	12	44.4
Team development skills	12	44.4
Health education principles	12	44.4
Biostatistics	10	37.0
Health policy mechanisms	7	25.9
Health services administration	4	14.8

The respondents had demonstrated a commitment to ongoing education with the majority stating they had attended courses since their basic training. One third (n=11) had achieved a university degree in nursing or other subject area.

Table 3. 8

Post Basic Training - Additional Education Obtained

Level	Yes		No	
	n	%	n	%
Course (N=27)	16	59.3	11	40.7
Certificate (N=27)	7	25.9	20	74.1
Undergraduate degree (N=27)	11	40.7	16	59.3
Graduate degree (N=27)	4	14.8	23	85.2

Current scope of practice for registered nurses in primary health care

The survey contained a number of questions about the scope of practice of the nurses currently working at the two sites. Respondents were asked for their perceptions regarding nursing education requirements for the job, the importance of various nursing

roles and the involvement of nurses in various functions of the sites. Respondents were also asked whether the skills, abilities and education of registered nurses were being used to their full potential. Registered nurses and managers were asked about nursing involvement in addressing health care determinants and nursing input into decisions. In addition, registered nurses were asked to identify the level at which they provided services and about their interaction with community organizations.

Level of Services

Nurses were asked to indicate which group or groups they considered to be their clients (more than one answer could be indicated by each respondent). Since all of the registered nurses provided direct care to individual clients, it was unsurprising that 100% of the respondents identified the individual as the level at which they provided services at the two job sites. Although primary health care is defined as "the first level of contact of individuals, the family and community with the national health care system" (WHO, 1978, p. 429), nurses were less likely to see families (n=20) and communities (n=10) as their clients.

In the interviews, seven registered nurses and four managers referred to the various levels of services provided by the nurses. According to interviewees, the levels of services are evolving as "we're just paving the way for primary health care in the region" and the two settings may not have existed long enough for the relationship to develop with communities. One interviewee said that she found in her practice that she was

> making connections and trying to facilitate and bring information and resources to the community. And always trying to assess the community for what their needs are…Your focus in community can be an individual but you're approaching it from a community background as opposed to going in for a patient assignment and kind of more specific. Fostering relationships with a community takes a

> lot more time and definitely a lot more time than you can foster one with a patient.

One manager suggested that the focus of nurses should not be on assessing population needs as

> in the [region], there are certainly some people who look at the population from a broader perspective and they're not necessarily nurses. We have an entire unit that is responsible for population health and they look at more from a policy and broader strategy level. So I would say that at the higher level, there are other people besides nurses who look at it that way.

One interviewee believes that the next step

> in our evolution is to be more integrated within other health care providers within the community … non-health care as well, so that we're more of a support to the community as a whole as opposed to a stand alone organization and so I think that the role of the nurses will evolve from that…A lot of our public health nurses in particular are already interested in and involved in projects with homeless shelters and other kinds of service providers.

One interviewee suggested that the skills of nurses are

> …probably underutilized right now. I bet they're not spending enough time on looking at the family in the context….even though that is the nursing role, they're really quite medical here.

However another nurse said

> Of course, you're always, always involved with the families. It's rare that you don't have a family member that you would know by name and contact.

Several interviewees felt that nurses were currently providing nursing care to the community with one nurse saying she had experienced a "total submersion in social action which happened immediately when I took on the job."

Another nurse commented that having the community as a client had changed the skills she required for her practice; in particular she identified facilitation skills as a need

for nurses working in the community. The nurses in her group, having received training, decided that the community could also benefit from developing their facilitation skills:

> We've also invited some of the mums who we've identified as leaders in the groups to come and take the facilitator training as well so maybe they can launch another group from this group…so that they have some transferable skills to be independent from our group.

The link between community and the primary health care system is perceived as reciprocal and differs from the medical model in that it does not foster dependence upon health professionals.

Table 3.9

Level of Services Provided by Registered Nurses

Stakeholder Group	Individual		Family		Group		Community		Population	
All RN Respondents (N=27)	n	%	n	%	n	%	n	%	n	%
	27	100	20	74.1	11	40.7	10	37.0	6	22.2

Job requirements and nursing education

The three respondent groups agreed that education in teamwork and health education principles were important for the work that nurses were performing at the two project sites. Although managers felt very strongly about the importance of education in teamwork (n=7), the strength of their beliefs dropped for their other top answers of primary health care principles (n=5) and health education principles (n=5). Managers and nurses were less likely than physicians to agree that education in primary health care principles was important for nurses' work. No managers believed that education in nursing research was important. This was a surprising result since the two study sites are primary health care research sites. Managers may believe that while the nurses collect

data and deliver the programs, they do not function as principal investigators and, therefore, do not need to have nursing research education to deliver nursing care.

Education in biostatistics and health policy mechanisms were seen as relatively unimportant for the jobs at the two sites by all three respondent groups.

Table 3.10

Nursing Education is Necessary to Perform the RN Job - Strongly Agree and Agree

Area of Education	RNs			Managers			Doctors		
	N	n	%	N	n	%	N	n	%
Public health nursing	26	20	76.9	7	2	28.6	16	14	87.5
Biostatistics	25	14	56.0	6	0	0	16	5	31.3
Nursing research	26	20	76.9	6	2	33.3	16	6	37.5
Health Services Admin	26	10	38.5	6	0	0	15	4	26.7
Health Policy Mechanism	27	12	44.4	6	3	50.0	16	6	37.5
Primary health care	24	18	75.0	7	5	71.4	16	14	87.5
Teamwork	27	26	96.3	7	7	100	16	16	100
Community advocacy	26	20	76.9	7	4	57.1	16	14	87.5
Health education principles	27	24	88.9	7	5	71.4	16	16	100
Epidemiology	25	17	68.0	6	2	33.3	15	9	60

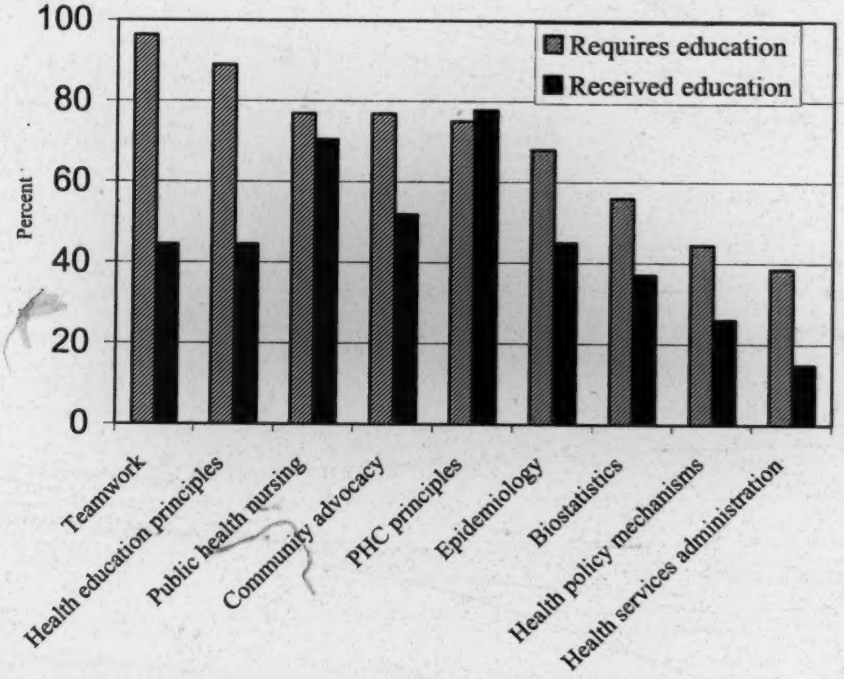
Table 3.11

Nursing Education is Necessary to Perform the RN Job - Strongly Disagree and Disagree

Area of Education	RNs			Managers			Doctors		
	N	n	%	N	n	%	N	n	%
Public health nursing	26	2	7.6	7	2	28.6	16	0	0
Biostatistics	25	3	12.0	6	2	33.4	16	4	25.0
Nursing research	26	1	3.8	6	1	16.7	16	1	6.3
Health Services Admin	26	4	15.4	6	1	16.7	15	1	6.7
Health Policy Mechanism	27	5	18.5	6	1	16.7	16	3	18.8
Primary health care	24	2	7.4	7	1	14.3	16	0	0
Teamwork	27	0	0	7	0	0	16	0	0
Community advocacy	26	0	0	7	1	14.3	16	0	0
Health education principles	27	0	0	7	0	0	16	0	0
Epidemiology	25	1	3.7	6	1	16.7	15	0	0

A cross-tabulation was calculated between the nursing education that nurses reported receiving and the education that they believed was required for the jobs that they were currently performing.. The areas which were identified by nurses as most requiring of education such as teamwork (n=26) and health education principles (n=24) were also areas where less than half of the nurses had reported receiving nursing education (each n=12). A split was also reported between education received in health services administration (n=4) and the importance of the area (n=10) for the job that nurses were performing. Figure 3.1 represents the results of the cross-tabulation

Figure 3.1. Cross-tabulation of job requirements and nursing education. A cross-tabulation of percentage of registered nurses reporting that they strongly agreed or agreed that their current job required education in these areas and percentage of registered nurses reporting that they strongly agreed or agreed that they had received education in these areas.



Importance of RN Roles

Respondents were asked to indicate which roles of registered nurses were important in the primary health care environment in which the nurses were currently working. The three stakeholder groups agreed that the roles of resources for clients and teachers of clients were important for nurses. The role of community developer received the lowest support from physicians (n=6) and managers (n=3) with registered nurses indicating that only the roles of evaluator of service (n=11) and policy developer (n=8)

were less important than community developer (n=13). A summary of the results is contained in Table 3.12; please see Appendix G for the full results.

Table 3.12

RN Roles That are Important in Current Positions

Stakeholder Group	Strongly agree/agree*	Strongly disagree/disagree	
RNs	Resource for clients Teacher of clients Liaison with other community orgs. Client advocate Team member Health Promoter	Community developer Policy developer Program planner	
Managers	Resource for clients Teacher of clients Direct care provider Coordinator of client care Liaison with other community orgs. Client advocate Team member Consultant to other health team members Facilitator of care	Policy developer Community developer Health promoter) Team leader) Resource planner) Evaluator of services)	Tied
Physicians	Resource for clients Teacher of clients Health promoter	Community developer Evaluator of services Resource planner	

* all strongly agree/agree responses were tied at 100%

In addition, registered nurses were asked whether they perceived their roles as having been clearly defined. Given that both of the practice settings are regional projects established less than 5 years ago, it is not surprising that almost a third felt that either their roles had yet to be clearly defined or were unsure whether their roles had been defined.

Table 3.13

The Role of Registered Nurses is Clearly Defined

Stakeholder Group	Strongly Agree/Agree		Neutral		Strongly Disagree/ Disagree	
	n	%	n	%	n	%
RNs (N=18)	12	66.6	2	11.1	4	22.2

Involvement in site activities

All of the stakeholder groups agreed that registered nurses were involved in both planning and providing education for clients of the sites. Registered nurses were unsure about their participation in determining what services will be provided and in providing education sessions, developing their job description along with their involvement in the selections of clients for educations. Again this could be related to the developing nature of the nursing positions at both study sites giving rise to a lack of role clarity.

Managers also indicated that they felt neutral regarding the involvement of nurses in the selection of clients for education. In addition, managers identified feeling neutral about nursing involvement in planning programs, implementing programs and planning the budget. The top three responses in the two categories of "Strongly Agree/Agree" and "Strongly Disagree/Disagree" have been reported in Table 3.14.

Table 3.14

Nursing Involvement in Site Activities

Stakeholder Group	Strongly agree/agree	Strongly disagree/disagree
RNs	Independently identify education needs Plan education for clients Involved in selection of clients for education } tied Provide education sessions }	Development of own job description Involvement in selection of clients for education } tied Determining services to be provided by site }
Managers all strongly agree/agree responses tied at 100%;	Evaluating programs and services Planning education for clients Providing education for clients Identifying needs for client education	Planning the budget Development of their job description Planning programs and services
Physicians all strongly disagree/disagree answers tied at 6.3%.	Implementing programs and services Providing education sessions Planning education sessions	Planning programs and services Evaluating programs and services Planning education for clients Selecting clients for education Providing education sessions

Registered nurses working to full potential

Each stakeholder group was asked to indicate their agreement with the statement that the education, skills and abilities of nurses were being used to their full potential. While all physicians (n=7) who responded and managers (n=6) believed that this to be true, registered nurses were less convinced. [The response rate of the physicians may be related to the position of the question at the top of the survey page or they may have not felt qualified to provide a response.] Just over half of the registered nurses strongly agreed or agreed that their education, skills and abilities were being used to the fullest extent.

Table 3.15

Full Potential of RNs is Used

Stakeholder Group	Strongly Agree and Agree		Neutral/Don't Know		Strongly Disagree and Disagree	
	n	%	n	%	n	%
RNs (N=25)	14	56.0	7	28.0	4	16.0
Managers (N=7)	6	85.7	0	0.0	1	14.3
Doctors (N=7)	7	100	0	0.0	0	0.0

The lukewarm response of nurses to the question of currently working to their full potential prompted further exploration of their responses. Through cross-tabulation, the association between the reporting of full potential utilization and the year of graduation from basic nursing program was examined. The subjects were placed into three categories that were designed to identify those who had graduated before primary health care was developed (1960s and 1970s); the decade immediately following the development of the concept (1980s); and the decade when professional associations began to incorporate the concept into the scope of nursing practice (1990s). Registered nurses who graduated in the 1960s were twice as likely to feel that their potential as registered nurses was being used to the fullest extent possible than nurses who graduated in the 1990s.

Table 3.16

Full Potential of Nurses is Used (By year of graduation)

Year of Graduation	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	Percent	n	Percent	n	Percent
1960s/1970s (N=9)	7	77.7	2	22.2	0	0
1980s (N=6)	3	50.0	1	16.7	1	16.7
1990s (N=12)	4	33.4	4	33.3	3	25.0

Leadership

In order to measure the beliefs about the leadership role of primary health care's multidisciplinary team, the stakeholder groups were asked to identify their agreement with the following statement: *The team leader should always be a physician*. Physicians were the most likely to agree with the proposition (n=6); however, an almost equal number of physicians indicated they were unsure about whether the leadership role must be occupied by a physician (n=5). No respondents from either the registered nurse or manager stakeholder groups supported the statement. In fact, nearly all (n=25) of registered nurses disagreed that the team leader should always be a physician. This finding may reflect confusion amongst health professionals regarding the roles of team members (DHSS, 1986; Audit Commission, 1992). Since the team approach inherent in primary health care is a relatively new departure from the physician-led medical model, it would not be surprising that artefacts remain from the older approach. The finding may also reflect a feeling of confidence of those registered nurses who responded to the survey or that nurses have embraced a team concept wherein they are equal partners.

Table 3.17

Team Leader Should Always Be a Physician

Respondents	Strongly agree/agree		Neutral/Don't know		Strongly disagree/disagree	
	n	%	n	%	n	%
RNs (N=27)	0	0.0	2	7.4	25	92.6
Managers (N = 7)	0	0.0	1	14.3	6	85.7
Physicians (N=16)	6	37.5	5	31.3	4	25.0

The general beliefs about the leadership role were then compared to the participants' perceptions of what was taking place in the clinical settings.

As illustrated by Table 3.18, registered nurses were the least likely to agree (n =2) that physicians were actually always the team leader at their sites. Once again the perceptions of the physicians varied from the registered nurses about the leadership role as physicians were nearly five times more likely to see members of their profession as the current leaders of the team.

Table 3.18

Team Leader Is Always a Physician

Respondents	Strongly agree/agree		Neutral/Don't know		Strongly disagree/disagree	
	n	%	n	%	n	%
RNs (N=27)	2	7.4	4	14.8	21	77.7
Managers (N = 7)	2	28.6	1	14.3	4	57.2
Physicians (N=15)	5	31.3	7	43.8	3	18.8

Concerns about leadership of the multidisciplinary team did not appear to resonate with interviewees. The health professionals involved with the project sites are likely to have a commitment to the success of the project and avoided discussion about the leadership of the teams. As one interviewee did say

> I don't want nurses to be territorial like say the medical profession has been. They're so hung up on the medical model that they don't work really well with other professions…I don't want to get hung up on which profession is to head the department; maybe they can rotate through…the idea of multidisciplinary teamwork works. It's been shown in research that it does work and we don't do enough of that and that's to the detriment of our clients.

Primary health care practices

Health determinants – addressing barriers. Registered nurses and managers were asked about current RN involvement in health determinants such as poverty and unemployment that are not part of the traditional medical model but which are seen as important issues to be addressed in primary health care. More than two-thirds of

registered nurses (n=19) believe they play a role in addressing barriers to health such as poverty and unemployment in their current positions. Approximately the same percentage (n=5) of managers said they encouraged the registered nurses at the two sites to play a role in addressing these barriers to health.

During the interviews, four registered nurses, one manager and one physician discussed the roles that nurses can play with regards to addressing the barriers for individual clients. Two interview respondents mentioned specific examples of how nurses address the barriers for both individual and community clients. According to one manager,

> …a young guy who was basically out on the street trying to get himself better. He was working construction but would come in with sores all over his feet because he was wearing a size 10 shoe instead of a 12 and they're not work boots…we do keep a little bit of clothing here which is a huge issue, especially when they're homeless. We do a lot of homeless awareness so she phone up to Mountain Equipment and got the manager and got a new pair of boots.

This allowed the young man to be physically able to work. The nurse involved then went on to work with the community development coordinator to expand the footwear donation program to other community based businesses.

Table 3.19

RNs Play a Role in Addressing Barriers

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N=27)	19	70.4	5	18.5	3	11.1
Managers (N=7)	5	71.5	2	28.6	0	0.0

Input into decisions. Nurses and managers were asked whether they perceived that the nurses had input into decisions that affected their nursing practice because they have detailed knowledge of nursing practice. Just over two-thirds of nurses (n=19) agreed or strongly agreed that they had input into decisions that affected their nursing practice. Three quarters of the managers (n=3) who responded agreed that nurses had input.

The single interviewee who provided specific information about how the nurses' input had been obtained (through committee work on communication, orientation, flow, ergonomics committees) emphasized that the employer had actively supported the participation of nurses on the committee through backfilling for absences greater than 2 hours.

Table 3.20

RNs Have Input Into Decisions Affecting Nursing Practice

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N=25)	19	70.3	4	14.8	2	7.4
Managers (N=4)	3	75.0	1	25.0	0	0.0

Community organizations. According to the survey results, a majority of registered nurses work with other community organizations to enhance the health of their clients. Although registered nurses did not identify the community as a client (see Level of Services above), interviews revealed they have embraced the primary health care principle of collaboration with community organizations in order to meet the health needs of their individual and family clients. Community resources are called upon but not seen as the client of the primary health care nurse.

During the interviews, six registered nurses, one manager and one physician discussed the ways in which registered nurses actively work with other community organizations with activities such as providing health support at shelters and working on a seniors' fall prevention program with organizations such as AADAC, Bethany Lifeline, EMS and CareWest.

One of the registered nurses spoke about the relationship of nurses with community resources:

> [the nurse] is like a jack of all trades…that's true in community too. We work bringing in resources, hooking them up with co-workers who are experts… connecting them up with other community resources like police officers … I still sort of see the nurse in community as being an advocate for the community and linking them up with the resources but not necessarily being the expert themselves.

Another nurse interviewee saw the connection with the community organizations as a natural part of the nursing scope of practice:

> When you're looking to try and support the client in the community, once they're gone beyond us, you're phoning shelters, treatment centres, you're trying to link this person up to other resources; that's well within nursing. It's just different from what acute care often does. And that's something different but it's not outside the scope, it's just different from the usual stuff.

Several interviewees also referred to the importance of the position of community developer in facilitating the community connections.

Table 3.21

RNs Work with Other Community Organizations

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N=26)	22	81.4	4	14.8	0	0.0

Facilitators and barriers of scope of practice

This section examines factors relating to research question #2 "What are the facilitators and barriers to registered nurses working to their full scope of practice within an evolving primary health care practice setting?"

The stakeholder groups were asked questions about the ability of nurses to provide all of the services that they were capable of providing (their scope of practice). In order to facilitate presentation of the results, the findings have been grouped into the elements of the conceptual model.

Clients

Respondents were asked to indicate their level of agreement with statements about the effect of clients on the scope of nursing practice. Questions included the type of client, client needs and clients' expectations of registered nurses.

Survey results suggested that the types of clients impacted the nursing scope of practice; however, this element did not seem to resonate with interviewees. While many of the interviews respondents discussed the types of clients and the need for nurses to work with different populations, no interview respondent suggested whether or how the client population expanded or constricted nursing practice.

Table 3.22

Types of Clients Affect Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 26)	20	74.0	4	14.8	2	7.4
Managers (N=7)	6	85.7	1	14.3	0	0.0
Physicians(N=16)	15	93.8	1	6.3	0	0.0

Generally, survey respondents were more supportive of client needs as an influence on nursing practice than they were for the other two components (client types and perceptions) of the Client Factor for the conceptual model. All interviewees did refer to client needs as a driving force behind the types of programs offered at the two study sites.

One interviewee related how individual client needs affected her practice:

> [It's] important in terms of, from a nursing perspective, being able to assess where the patient is at or the client is at and assisting the client in meeting their own needs and making sure that there is an adequate assessment done so that other health care needs are met in a general sense…my role was always to work with the patients… in urgent care, obviously, it's a little bit more specific to what they came in for ... their goals are different obviously and then you have to work within the context of a larger team.

Two interview respondents described programs that had been developed as a result of the identification of client needs:

> The baby chat was developed by us. We saw a gap. We used to, years ago, offer a postpartum support group, and they did some changeover in the region with how they were run and we found there was a gap and there was a need for clients in our area so we actually took on a community development project. We applied for funding for a program…able to get funding to run the program and it's been going for 2 years now. We have a nurse as facilitator…we've just planned a facilitator training course for the fall.

Another nurse pointed to different area within the regional health authority where the level of client needs was such that

> [the nurse] was involved with agencies and inter-agency meetings and being able to link with some more partners in the community. I would say she had probably more opportunity than the rest of us just because she was a nurse that spent a lot of time in that community that had high needs.

Table 3.23

Client Needs Affect Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 27)	26	96.3	1	3.7	0	0
Managers (N= 7)	7	100	0	0	0	0
Physicians (N=16)	16	100	0	0	0	0

While virtually all of the survey respondents believed that the expectations of clients had a bearing on the scope of nursing practice, none of the interviews elicited client expectations as either a barrier or facilitator.

Table 3.24

Client Expectations Affect Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 26)	24	88.9	2	7.4	0	0
Managers (N=7)	7	100	0	0	0	0
Physicians (N=16)	16	100	0	0	0	0

Practice Setting

Respondents were asked whether workload, the funding of programs and the makeup of the health care team affected the ability of nurses to provide all of the care that they were capable of providing. The survey responses indicated that all three stakeholder groups believe that this conceptual element plays an important role in determining what nurses are able to do.

The interviews confirmed that the makeup of the health care team influenced nursing practice with seventeen interviewees providing some form of commentary.

Several interview respondents commented on areas of overlap between physicians, nurses and other health professionals. In fact, according to one interviewee, a goal at one of the project sites was to look for

> significant role overlap so that we don't have to divvy the patient up into what the doctor does, what the nurse does and what the dietician does. But wherever possible…ensuring that the patient benefits from the skills from each of the professionals involved …we will be looking for performance at a higher level for nurses and dieticians and enable physicians to focus on the things they like to do and do best and enabling them to take care of either higher complexity caseload or the same complexity and higher number of cases so increasing capacity though building a team.

One nurse expressed reservations about whether doctors would be prepared to embrace the multidisciplinary team concept saying "doctors are pretty protective of their territory and so I think there's going to be a lot of education." Four respondents reported that in their experience nurses were able to do much more when they practiced outside of the city limits where there are fewer members of the health care team. One nurse said, "The further north you go, the smarter you get, apparently."

One nurse compared her primary health care practice with her institutional based practice saying

> I used to work in the hospitals a while back and I just found it very restrictive and that mostly the doctor made all the decisions whereas [now] I collaborate with the team as to 'okay, this is the client's goal; this is what we want to see for them' … it's not one person holding the reins.

Relationships among team members were stressed as important factors for nurses being able to perform their full scope of nursing practice according to three interviewees. One manager suggested that the relationship between the team was a prerequisite to the delegation of tasks in one model. The facilitation of client-care related communication

between health care team members was also cited as providing nurses with an ability to expand the care they provided.

Table 3.25

Make-up of Health Care Team Affects Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 27)	26	96.3	1	3.7	0	0
Managers (N=7)	6	85.7	1	14.3	0	0
Physicians (N=16)	14	87.5	2	12.6	0	0

The majority of survey respondents were conscious of the effect that the funding of a program area can have on the scope of care that nurses are able to provide. Seven nurses and one physician confirmed the finding in the interviews. One nurse said that the lack of funding constrained what she was able to do because "I have to see the maximum number of people to make it financially feasible for this position to be sustainable" thus limiting her ability to provide more than a limited type of nursing care. Another nurse felt that she had been able to expand what she was able to do by obtaining funding for a program through a community development model.

Table 3.26

Funding of Program Area Affects Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 27)	25	92.6	2	7.4	0	0
Managers (N= 7)	7	100	0	0	0	0
Physicians (N=16)	14	87.5	2	12.6	0	0

In the interviews, seventeen respondents (9 RNs; 4 Managers; 4 Physicians) identified workload related issues as having an impact on the scope of nursing practice. For the purposes of this analysis, comments surrounding the lack of time were included with the workload element as the two themes are inherently linked. One nurse described the lack of time as the greatest limitation for nursing.

According to one interviewee, one of the projects was

> …dependent on home care releasing nurses time to work with these particular teams by splitting off their caseloads and workloads to other nurses to free them up...very critical for this project a lot of time in that community that had high needs.

Nurses spoke about the difficulties presented by time and workload to nursing practice. One nurse said, "When time is of the essence, you have to be a wizard to establish a rapport to the extent where [clients] will accept what you have to offer." Another decried the lack of time saying

> …a positive about the [site] is that we look at the whole person not just the situation or the illness, the presenting problem. There's a lot of education and it's really powerful to be able to have the green light to go ahead and educate. The downfall is that we don't always have that time to educate because we're getting busier and busier.

Physicians noted that the workload restrictions of physicians meant that certain primary health care services are being performed by nurses. One interviewee felt that nurses had more time to

> approach patients more of a social aspect. Now, we can't do that…if a patient says "Doctor, I can't afford this'…we say 'Look , have you been in touch with social services' Now that's the sort of thing where the nurse can advise the patient better than we can because I can't sit on the phone or my staff can't sit on the phone arranging some support from social service which the patient may require…housing, their living conditions…

Another nurse linked the issues of workload and funding saying

> ...because health is an industry now, it's really run like a business...There's a time limit, you can't spend the kind of time with clients... an excellent place to be able to establish rapport and do some anticipatory guidance...but you don't have the time now because we need numbers, numbers, numbers in order to justify funding, funding, funding.

Table 3.27

Workload Affects Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 27)	26	96.3	1	3.7	0	0
Managers (N=7)	7	100	0	0	0	0
Physicians (N=16)	16	100	0	0	0	0

In addition to the above listed elements, two interview respondents suggested that a lack of workspace and diagnostic facilities affected what nurses were able to do. One of the nurses said that a lack of workspace meant that she wasn't able to do demonstrations for clients. Another nurse suggested that physical safety issues could also affect the comfort level of the nurses in performing their work but did not provide details.

Scope of practice

Respondents were asked to indicate whether professional legislation and the support of the professional association had an impact on whether nurses were able to provide the health care services of which they were capable. Although the majority of each of three groups agreed or strongly agreed that the legislated scope of practice affected nursing practice, this element of the conceptual model received one of the lowest levels of support of the five elements.

During the interviews, six registered nurses and four physicians raised the legalities surrounding the practice of nursing as a constriction on nursing practice. One nurse felt some trepidation at being responsible for adjusting medications:

> I think sometimes that the medication thing is sometimes a little, sometimes I think I'm given almost a bit too much free rein and you feel this is on your [nursing] license.

Three of the interviewed physicians and two of the registered nurses pointed out that the professional legislation was not limited to that which specifically applied to registered nurses. One doctor noted, "They're limited by the fact they're not physicians and so they still come to me… those kinds of boundaries which are appropriate boundaries."

A question about whether nursing in the community-based primary health care setting was closer to real nursing prompted this response from one nurse:

> Yes, in the hospital, you're circumvented by the profession, you're overlapping with what's in the territory of the medical profession…That overlap, that medical basis, taints nursing in a different way. Whereas in community you don't overlap with the medical profession as much – that's more peer nursing.

Table 3.28

Professional Legislation Affects Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 27)	23	85.2	33	11.1	1	3.7
Managers (N= 7)	6	85.7	1	14.3	0	0
Physicians (N=16)	11	68.8	5	31.2	0	0

While support from the professional association was seen as important to the registered nurse who responded to the survey, only one interviewee mentioned the area as

an influence on whether nurses are doing all of which they are capable. The degree of neutrality on the part of managers and physicians was reflected in the interviews where none suggested a link between the professional association and the scope of nursing practice.

Table 3.29

Support from Professional Association Affects Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 27)	25	92.6	1	3.7	1	3.7
Managers (N=7)	4	51.2	3	42.9	0	0
Physicians (N=16)	12	75.0	4	25	0	0

RN Attributes

Questions about RN attributes included the areas of personal characteristics, nursing education, nursing experience and perception of nursing roles. RN attributes were seen as important factors influencing nursing practice. Nearly all of the survey respondents reported that they strongly agree or agreed that individual attributes affected what nurses were able to do.

This finding was supported in the interviews as it elicited the largest number of comments of all of the conceptual elements. Interviewees spoke about the role of nurses being influenced by everything from communication, negotiation and relationship building skills to personality, creativity, nursing ingenuity (a combination of education, experience and personality) and enthusiasm.

Assertiveness in the negotiating of the relationship was seen as important by one physician who said

> Maybe at the beginning there should have been a little more discussion of what people thought their skills sets were, what they could bring to the collaboration… a little more upfront work about what she saw her role as and what she could bring and negotiate who would do what .

In response to a probe about whether nurses needed to use negotiation skills, one respondent said

> Yes…because if they don't have good relationships, it's not going to work out. They need very good interpersonal skills for this job. And they have to be strong to stand up for themselves and what they think needs to be done because they're out there on their own.

Self-confidence and a comfort level with taking on more responsibilities were also cited by interviewees. Two physicians commented on the comfort zone of nurses with one physician saying

> It varies from person to person as well – that there are certain nurses who might want to take on more responsibility but others wouldn't be comfortable. So some nurses might enjoy it, taking on other challenges there, but others might say no, I've got enough on my plate. So I think that's more a personal thing.

Two nurses also commented that the ability to build trust with other team members had been crucial to what they were able to do as nurses in the past.

Table 3.30

Personal Characteristics Affect Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N=27)	27	100	0	0	0	0
Managers (N=6)	6	100	0	0	0	0
Physicians (N=16)	16	100	0	0	0	0

Nursing education and experience were seen as critical by all survey respondents; this was supported by comments made by interviewees. In fact, the managers stated that they had been looking for nurses with certain types of training and certification along with community and chronic disease management experience. One manager said that because they considered most of the site's roles to be advanced nursing [although an extended practice certificate was not a requisite for any of the jobs], nurses required several years of experience before being considered for the setting.

Three nurses felt that barriers to nursing practice could be alleviated by educating physicians about what nurses were qualified to perform. One nurse said that she found that although she was a specialist in her area, "we're women and we're nurses and that doesn't cut it often times with [doctors]."

Table 3.31

Nursing Education Affects Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N=27)	27	100	0	0	0	0
Managers (N=7)	7	100	0	0	0	0
Physicians (N=16)	16	100	0	0	0	0

Table 3.32

Nursing Experience Affect Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N=27)	27	100	0	0	0	0
Managers (N=7)	7	100	0	0	0	0
Physicians (N=16)	16	100	0	0	0	0

Perception of the nursing role also received strong support from survey respondents. One physician interviewee said that nurses had limited their scope of practice which

> has to do with how they perceive their roles and what they can control…They seem to want to leave all the decisions to me. What they do is they identify problems and they make recommendations but they really aren't aggressively pursuing any management strategies.

One nurse pleaded for nurses to expand their perception of the nursing role saying

> A lot of people are content with what they're doing. If you think of our professional development and progressing the field of nursing, if you remember that's supposed to be part of your nursing role…taking care of nursing as a profession and advancing the field.

Table 3.33

Perception of Role Affects Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N=27)	26	96.3	1	3.7	0	0
Managers (N=7)	7	100	0	0	0	0
Physicians (N=16)	14	62.5	1	6.3	1	6.3

In addition, survey respondents were asked for more detail surrounding the types of personal characteristics that were important for registered nurses working at the study sites. The survey listed six attributes that were found in the literature: flexibility, accountability, being self-directed, political consciousness, social awareness and having a health (versus illness) orientation. The full results are contained in Appendix H. While no registered nurse or manager respondent disagreed that being politically aware was a characteristic that affected the scope of nursing practice, support was less strong than for other characteristics. Although the provincial nursing association has taken the position that legislative, policy and funding decisions have placed barriers for primary health care implementation, health professionals do not appear to have linked these impediments to the scope of nursing practice. This may reflect a belief that the need to remove these barriers is perceived as the job of health care administrators and politicians.

Employer Requirements

Survey respondents were also asked if employer requirements such as job description, employer policies, employer expectations and employer support had an impact on nursing practice. A majority of respondents saw the four components of employer requirements as a factor affecting what nurses are able to do.

Two interview respondents mentioned the job description of nurses but only one suggested that there was any influence on the scope of nursing practice. Although job descriptions are intended to be legal documents that provide the specific responsibilities and complexities of various positions, nursing jobs at the two sites were still relatively early in the process of development.

Table 3.34

Job Description Affect Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 27)	25	92.6	2	7.4	0	0
Managers (N=7)	6	85.7	1	14.3	0	0
Physicians (N=16)	13	81.3	3	18.8	0	0

Due to the relative newness of both sites, specific written policies were not readily available; however, the sites did operate within the regional policy framework. This lack of availability may have affected the interview results for the impact of employer policies on nursing practice as no interviewee commented on employer policies as a facilitator or barrier to nursing practice.

Table 3.35

Employer Policies Affect Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 27)	24	88.9	3	11.1	0	0
Managers (N=7)	7	100	0	0	0	0
Physicians (N=16)	13	81.3	3	18.8	0	0

Employer expectations were not identified as a particularly strong factor by survey respondents. One interviewee spoke specifically about how nursing practice is affected by the employer's attitude towards community based services saying, "...going down to the main office for the [region], you realize what a big machine you're in...You can only get as big as the box you're put in."

Another nurse added that

> ...nurses are becoming more and more educated and I think are actually being able to cover a lot of the role of, let's say doctors for instance...I just see us as going up where RNs are more like nurse practitioners and we're just kind of all moving up a notch in our field and how we're educated and just with all the different things we're exposed to ... But, the thing is, our agencies, have to allow for that. And that's where the limitation is. I don't think the limitation is in the people or the nurses; I think it's the agencies and the jobs we work in.

Table 3.36
Employer Expectations Affect Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 27)	24	88.9	3	11.1	0	0
Managers (N=7)	6	85.7	1	14.3	0	0
Physicians (N=16)	14	87.5	2	12.6	0	0

Four interview respondents felt that employer support had allowed nurses to work in certain ways or on various community collaboration initiatives. In response to a probing question about whether manager support made a difference to what nurses were able to do, one interviewee answered emphatically,

> Definitely, if you have a manager that you're clashing with and isn't encouraging you to do the things and you're always having to get support and you're doing things with always having to check with her and always if you're doubting whether or not she's going to approve all of the work that you've put into something, that would really be frustrating. It's a very important part.

One nurse asserted that the lack of employer support could effectively restrict nursing practice:

> ...[a] lack of resources, lack of ability to get things like resources if you need to, lack of ability to get education in different areas that

> you're interested in or things that you think may be useful to your practice, not having the funding to be able to go to those in-services or workshops, that type of thing.

Two nurses suggested that employer support also needed to go beyond the workplace. Since the personal characteristics of the nurse play a role in what registered nurses do, employers should be cognizant that when nurses are stressed by their personal lives, they are less likely to take on additional roles at work. The nurses suggested that additional employer support when nurses are dealing with personal issues would be of benefit; neither provided details of what kinds of support would be of benefit.

Table 3.37

Employer Support Affects Whether Nurses are Doing All That They are Capable of Doing

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	%	n	%	n	%
RNs (N= 27)	27	100	0	0	0	0
Managers (N=7)	6	85.7	1	14.3	0	0
Physicians (N=16)	16	100	0	0	0	0

CHAPTER IV
DISCUSSION AND IMPLICATIONS

This Chapter provides an analysis of the data described in the previous chapter. The current scope of practice for nurses providing primary health care services is examined. Limitations that may inhibit the application of the study results are discussed. Policy implications are provided and suggestions are made for future research.

Current Scope of Practice

The literature review led to expectations that registered nurses would adopt roles beyond the medical model role of direct care provider. According to the findings of this study, the traditional nursing role continues to be one of the chief responsibilities of nurses working at the primary health care sites that participated in this study. [There was no suggestion in the literature that each registered nurse was expected to include all of the roles contemplated for primary health care in her daily practice.]

The study revealed that the nurses also identified themselves as client advocates and team members. Activities such as acting as a resource for the client, promoting health, liaising with community organizations and educating clients are seen by nurses as important. The health care professionals who participated in the research at the two sites indicated that registered nurses working at those sites had not become fully engaged in the community development role. This finding is congruent with Martens' (1993) assertion that nurses would struggle with primary health care's emphasis on community advocacy. Another possible explanation for the finding is that nurses have attempted to provide community development nursing services but were impeded by barriers to intersectoral collaboration within the community such as "historical, political, technical,

cultural, linguistic, environmental or geographic constraints" (Barnes, 1995, p. 12). The existence of a community developer position at one of the project sites, while seen by two nurses as an aid to community development nursing initiatives, may also be perceived by other nurses to be the formal position responsible for that aspect of primary health care services.

Although both settings use primary health care models, the perceptions of registered nurses suggest that they have not yet incorporated the community as client in their daily practice. Registered nurses saw individuals (100% of respondents) and families (74.1%) as the major nursing care levels. Groups, communities and populations were significantly less important. In addition, while 70.3% of registered nurses surveyed said that they played a role in addressing barriers to health such as poverty and unemployment), according to interviewees, the majority identified the barriers for individual clients. This may be related to the lack of integration of primary health care in nursing models. The Prince Edward Island Conceptual Model of Nursing notes that "...most nursing theories do not conceptualize health in a social, economic and political context" (Munro et al, 2000, p. 40).

One interesting theme emerged around the factor of "Client" in the conceptual model. While several interviewees confirmed the survey results that client needs impacted nursing practice, the stakeholder groups at both sites remained silent about the influence of expectations of clients. This conflicted with the survey finding which indicated support for the element of client expectations. Examined in the light of the findings mentioned in the above paragraph, the question arises as to whether nursing practice has evolved to incorporate the principles underlying primary health care.

According to Spencer "...all changes in policy, philosophy and practice have implications for 'the patient'. Yet most models of the [primary health care team] see the team as an organisation doing something to or for the patient. Efforts to incorporate the patient's perspective have been patchy and have achieved only modest success" (in Pearson and Spencer, 1997, p. 6). The developers of the Prince Edward Island Conceptual Model for Nursing came to a similar conclusion after reviewing articles on nursing theories and models: according to Hughes, "the majority of nursing models focus on care of the ill client, with the client cast in a dependent role" (in Munro et al, 2000, p. 40). The results from this study support these perceptions that registered nurses continue to seek the best approach for the integration of primary health care with the scope of nursing practice.

In order to meet the needs of primary health care, Sheps suggested that the knowledge base of community-oriented nurses required "three elements: epidemiology and biostatistics, social policy and the history and philosophy of public health, and the principles and practices of management and organization" (in Goeppinger, 1984, p. 133). The registered nurses involved in the survey indicated that less than half of the nurses had received any nursing education on epidemiology, biostatistics, health policy mechanisms or health services administration. In addition, this study found that while just over two-thirds of the registered nurses participating in this study indicated that they had received education in primary health care principles during their nursing education, only 37% saw the community as the level of service at which they provide care.

The literature surrounding primary health care teams in the United Kingdom had suggested that there is confusion about the roles of the various health professions. In their

examination of the implications of cultural differences between physicians and registered nurses in primary care, Williams and Sibbald posit that "changing roles and identities across professional boundaries create a culture of uncertainty" (1999, p. 737). The findings of this pilot study confirmed that nurses are unsure of how clearly their own roles are defined in the primary health care setting. One third of nurses responding to the survey felt their work lacked clarity. This may be related to the newness of the two projects which had yet to establish an organizational entrenchment which would provide stable and defined roles for everyone involved.

The findings of the survey suggest that the role of leader of the health care team has not been definitively established. Registered nurses in this study did not think the physician should be, or in fact was the leader of the team; physicians were far more likely to believe that they should be or were the team leader. In the traditional medical model, the physician is seen as the team leader (perhaps because they are the first point of entry to health care); in primary health care, team members may see each other as partners in a multidisciplinary team. The resulting paradigm shift may not have fully occurred at the two sites – either by individuals or in the way the programs have been developed.

Registered nurses who participated in the survey and who had graduated most recently were the least likely to feel their skills, abilities and education were being used to their full potential in their current position. Since the interview did not include questions about full potential, no enlightenment of this finding was available. Some possible reasons for the finding include that nurses who received their education post-adoption of the primary health care paradigm are more aware of the diversity of roles and see the current practice at the sites as limited to individual client care and education. Since

further cross-tabulations between year of graduation and full potential with site worked could have led to identification of respondents, no contrast can be established between those nurses working in the project site that involved urgent care and those working at the other site.

Canada is currently in a nursing shortage which is projected to worsen over the next 5 years; recent graduates from nursing who find that their education, skills and abilities are not being used in the primary health care community setting may opt to shift to another area of nursing or, in the extreme case, may leave nursing altogether in search of a more fulfilling livelihood. Since Canada's federal, provincial and territorial governments have indicated their support for a move to a primary health care system, it will be important to ensure that the "real world" practice setting is aligned with the education and skill development of registered nurses.

Conceptual Framework

The conceptual framework developed for this study suggested that registered nurse attributes, clients, employer requirements, practice setting and professional/legislative scope of practice were factors affecting the scope of practice for individual registered nurses.

The perceptions of the three groups confirm the importance of the elements of the framework concerning factors important to scope of nursing practice. In addition, attributes of other team members and the ability of the nurse to negotiate relationships, appeared to be major issues for the nurses in this study.

Although the model did not predict that any one factor would have a more prominent influence on the scope, one factor elicited virtually unanimous support from

the respondents. Individual attributes of registered nurses (such as nursing education and experience) were perceived as having a great influence on what nurses were able to do.

The interviews in this study revealed that individual attributes of registered nurses were critical factors affecting scope of practice. The ability of individual nurses to negotiate nursing practice, develop relationships with other health care professionals, their personal motivation and assertiveness skills were elements that expanded the list of nursing attributes used for the survey.

The factor of the practice setting in this conceptual model also received comment from interviewees. Time constraints were considered noteworthy; in general, the more time a nurse had, the more that she would be able to do. Physicians identified that physician time constraints have led to an expansion of nurses' work boundaries into areas traditionally seen as those of physician.

Interestingly, given the interest and activity by Alberta's government in amending legislation governing the various health professions, it appears that those working in health care do not perceive the professional or legislative scope of practice definitions as playing the most significant role in what nurses are able to do in primary health care. Respondents may believe that the legislative and professional definitions are sufficiently broadly written that nurses providing primary health care services need not concern themselves with running afoul of the law or the profession.

Study limitations

Limitations of the study do not justify the generalization of the findings to a broader population. Limitations include the sample size and the response rates. Since the study was performed in two developing primary health care sites, the findings do not

allow for an interpretation that nurses working in primary health care enjoy a different or broader scope of practice than those working in other settings.

Sample size

Due to the small sample size, internal validity tests could not be performed with accuracy. Since the demographics of population from which the sample was drawn are not known, there is no ability to determine whether the sample was representative of the broader population working at the two sites (or to other primary health care sites outside of the regional health authority).

Response rate

The low response rate for the survey could be related to a number of factors including:

1. Timing of the study. The research was conducted over four months during the summer. This could have had an impact on the involvement of study subjects.
2. Research exhaustion. Due to the newness of the primary health care initiatives, staff members have been the subject of multiple data collection projects. This may have resulted in the population becoming reluctant to participate in yet another study.
3. Physician negotiations. Physicians at one of the sites were in the midst of negotiations with the Site Director over the issue of payment for non-patient care tasks. The physicians may have perceived this study as another task for which they should be remunerated.

Implications for Policy and Practice

This study revealed there is room to further adopt primary health care principles. In particular, as members of the primary health care team, nurses could play a greater role in community and policy development. In order to do this, nurses will need to expand their vision of their clients beyond the individual and their family to include the broader community within which they provide services.

The discrepancy between registered nurses and physicians in this study about the leadership of the health care team is an issue that needs to be addressed by managers. Left alone, the effectiveness of the multidisciplinary team could be reduced by a "tug of war" over leadership.

Given that many nurses felt that their skills, abilities and education were not fully used, administrators need to explore with their staff what other roles and tasks they would like to perform. While the area of extension of practice has received attention from the professional association and the government, it appears that nurses have room to expand their current level of practice without adding further certification or licensing requirements.

Recommendations for Future Research

Future research on the scope of nursing practice in primary health care should be conducted in the following areas:

1. confirmation of the pilot study results with a statistically significant sample;
2. verification of the results regarding the gap between nursing education and workplace needs with a larger sample;

3. an examination of why those nurses who have graduated more recently are more likely to say that they are working at less than their full potential;
4. further exploration of the elements of the conceptual framework to determine the relationship between the factors and to assess whether, and which, factors play the greatest role in determining scope of practice; and
5. an assessment of how changes to physician practice influence what registered nurses do in their practice.

Conclusion

Governments have stated their commitment to primary health care as a new way of providing health care services. Policymakers have suggested that a change from the predominant medical model to primary health care model requires new practice approaches; yet research has not examined the scope of practice of members of the primary health care team. This study has provided preliminary information about the scope of practice of registered nurses in the beginning stages of primary health care suggesting that the scope of nursing practice in the two study settings is affected by many variables. The data confirmed that attributes of the registered nurse, the clients involved, the practice setting, the professional scope of practice and employer requirements each play a part in what registered nurses are able to do in primary health care.

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APPENDIX A – RECRUITMENT POSTER

Are you interested in participating in a study about registered nurses?

A graduate student from the Department of Public Health Sciences at the University of Alberta is studying what services and activities registered nurses are currently performing in a community-based setting.

The purpose of the study is to gather information about the scope of practice of registered nurses providing primary health care services in a community-based setting. The study will also look at the factors that influence RN scope of practice.

An information letter and consent form for this study will be distributed to registered nurses, physicians and managers at _____.

If you are interested in participating or would like more information, please contact:

Melanie Chapman RN BScN (MPH student) at:
Phone: 780-492-8604 (collect calls accepted)
E-mail: melaniechapman@hotmail.com
Fax: 780-492-0364

University of Alberta

APPENDIX B – INFORMATION LETTER AND COVER LETTER

#1: **INFORMATION LETTER**

SCOPE OF PRACTICE

Information Letter

Date:

Melanie Chapman, Principal Investigator
RN, BScN (MPH student)
Department of Public Health Sciences

University of Alberta
Office #: 492-4647

Dr. John Church, Co-Investigator
Assistant Professor
Department of Public Health Sciences
University of Alberta
Office #: 492-8604

Re: Scope of Practice for Registered Nurses (Primary Health Care)

Study purpose: We are doing a study of the scope of practice for registered nurses. The purpose is to see what the current scope of practice is for nurses working in primary health care. We also want to know what facilitators and barriers exist for working to a full scope of practice.

What is involved: If you agree to be in the study, you will be asked to complete a questionnaire and participate in a follow-up 30-minute interview. The questionnaire will take about 15 minutes to complete. The questionnaire asks questions about the roles and characteristics of registered nurses with the _____ projects. In the interview, we'll be asking what makes it easier or harder to provide the kind of care that registered nurses are capable of providing.

Benefits/Risks: If you are in the study you may learn new things about scope of practice. Your contribution will assist us to provide the nursing profession and policy makers with knowledge about the factors that affect scope of practice. There are no known risks from participating in the study. The project has received ethics approval from the University of Alberta.

Confidentiality: Your name will not appear in this study. The researchers are the only ones who will have access to the information collected from the questionnaires. We would like to tape record the interview so that we don't miss any important points. The taping will only occur if you agree. The researchers are the only ones who will have access to the tapes. All information and the consent forms will be locked in a secure area at the University of Alberta for seven years. They will then be destroyed. The findings from this study may be published or presented at a conference. If this occurs, your name will not be used. All information will be held confidential, except where professional codes of ethics or legislation require reporting.

Freedom to withdraw: You do not have to be in this study if you do not wish to be. Even if you agree, you can withdraw at any time by telling the researcher; while the data collected must be retained for 5 years according to Ethics Board requirements, none of the data will be used in the data analysis. You do not have to answer any questions asked. Your job will not change if you are in the study. If you decide not to be in the study or drop out, your job will not change as a result.

Questions or concerns: If you have any concerns with how this study is being conducted, you can call the Study Supervisor, Dr. John Church, in Edmonton at (780) 492-8604, or Dr. Nicola Cherry, who is not involved in the Study, but is in charge of Dr. Church's Department (Public Health Sciences) at the University of Alberta. Her number is (780) 492-6408.

Please initial below to indicate that you have reviewed this letter.

_____ _____

Initials of participant Initials of researcher

#2: COVER LETTER TO PHYSICIANS

Date:

Physician Address

Dear Dr. X:

Primary health care is re-defining the roles and practice of every member of the health care team. Despite the support of health reformers for increased primary health care, little is known about the effects of PHC on scopes of practice. Research in other countries has suggested that health services may be compromised by a lack of clarity of team members regarding the skills, abilities and knowledge base of other groups.

A Master's thesis research project is examining the roles of registered nurses providing primary health care in a community-based service.

Physicians have traditionally played an important role in influencing the scope of practice of registered nurses. Thus, the researcher is interested in physician perceptions of the practice and roles of registered nurses working at the _____.

Enclosed, you will find a short questionnaire (which takes approximately 5-10 minutes to complete) along with an information letter and consent form. An invitation to participate in an interview, to be scheduled at your convenience by phone or in person, is also included. The interview would take 15-20 minutes depending upon the answers you provide. A stamped, addressed envelope is also attached. Please mail the consent form, agreement to participate in the interview and the questionnaire in the envelope provided by June 30, 2002.

Your participation in this project would be greatly appreciated - the insight of those who are the actual providers of health care is incredibly important to ensure that future health policy is based on a clear understanding of current roles and practices.

Sincerely,

Melanie Chapman, RN, BScN

APPENDIX C

CONSENT FORM

(Scope of practice of registered nurses)

Principal Investigator: Melanie Chapman

To be completed by research subject:

Do you understand that you have been asked to participate in a research study?	Yes	No
Have you received and read the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in participating in this research study?	Yes	No
Have you had an opportunity to discuss and ask questions about this study?	Yes	No
Do you understand that you are free to participate or withdraw from the study at any time? [No reason for withdrawal will be needed.]	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you agree to allow the researcher to audio-record your responses for analysis of data?	Yes	No
Do you understand who will have access to your research responses?	Yes	No

This study was explained to me by: _____

I agree to take part in this study.

_____ _____ _____

(Signature of research participant) (Date) (Printed name)

_____ _____ _____

(Signature of witness) (Date) (Printed name)

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____ _____

(Signature of investigator or designee) (Date) (Printed name)

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY PROVIDED TO THE RESEARCH SUBJECT.

APPENDIX D

SCOPE OF PRACTICE
RESEARCH PROJECT

Interview Participation

☐ I, _____(name), agree to be interviewed for this research project.

I would prefer to be interviewed:

☐ By telephone

☐ In person

My contact information:

Telephone number: _____

Dates and times available: _____

_____

_____

The researcher will contact you to establish an appointment.

☐ I, _____(name), do not agree to be interviewed for this research project.

Please return this form in the envelope along with completed questionnaire and consent form.

APPENDIX E

RN QUESTIONNAIRE

1. When did you graduate from your basic nursing training? _____(year)

2. What type of basic nursing training did you receive?

   Diploma ☐ Degree ☐

3. What, if any, education have you obtained since that time? (please specify)
   Certificate (s) _____
   Undergraduate Degree(s) _____ Graduate Degree _____
   Course(s) _____

4. How long have you worked in community-based care? (Please check one)

   Less than 1-year ☐ 1-3 years ☐ 3-5 years ☐ 5-10 years ☐ 10-15 years ☐

   16 years or more ☐

5. What other areas of nursing have you worked in? Please state how long you worked in each category.

   Medical ☐ Maternity/Labour & Delivery ☐

   Surgical ☐ Pediatrics ☐

   Critical care ☐ Gerontology ☐

   Emergency ☐ Other (please specify) ☐

   Mental health ☐

6. Did any of your nursing education include: (check applicable)

   Public health nursing ☐ Health policy mechanisms ☐

   Epidemiology ☐ Community advocacy ☐

   Biostatistics ☐ Team development skills (understanding of roles of other health disciplines, positive attitudes towards other health professionals) ☐

   Health services administration ☐ Health education principles ☐

   Primary health care principles ☐

7. How long have you worked at _____? (Please check one)

0-6 months ❒ 6-12 months ❒ 1-2 years ❒

2-4 years ❒ 4-6 years ❒ More than 6 years ❒

8. In your basic nursing program, did you spend clinical time in a community setting?

Yes ❒ No ❒

If yes, amount of time: Less than 1 week ❒ 1-2 weeks

2-4 weeks ❒ 4-8 weeks ❒

More than 8 weeks ❒

9. What is your position at _____? (Please check one)

Medical/urgent care nurse ❒ Public Health Nurse ❒ Home care nurse ❒

Mental health therapist (nurses) ❒ Health Innovation Fund Project nurse ❒

Community care coordinator ❒ End Stage Renal Disease Project Nurse ❒

10. At what levels do you provide services at _____? (Who are your clients?) Check all that apply.

Individual ❒ Family ❒ Group ❒ Community ❒ Population health ❒

Please indicate your level of agreement with following statements. If you have no opinion or don't wish to answer the question, please check "Don't know".	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Don't know**
My role as a nurse at _____is clearly defined.						
The following roles are important for me in my role as a nurse at the _____:						
Program planner						
Resource for clients						
Teacher of clients						
Teacher of other health care professionals						
Direct care provider						
Coordinator of client care						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know
Liaison with other community organizations Client advocate Team leader Team member Community developer Consultant to other health team members Facilitator of care for clients Evaluator of services provided by _____ Health promoter Illness and injury prevention Policy developer						
The following attributes are important for me in my role as a nurse at _____: Flexibility Accountability Self-directed Knowledge of primary health care Politically conscious Health (versus illness) oriented Socially aware Other (please list):						
In my role as a nurse at _____, I am/was involved in: Planning education for clients Development of my job description Independently identify needs for client education Involved in selection of clients for education Providing education sessions						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know
Determining what services will be provided by _____ Other (please list):						
I have input into decisions that affect my nursing practice.						
As nurse at _____, I play a role in addressing barriers to health such as poverty and unemployment.						
In my role as a nurse at _____, I work with other community organizations to enhance the health of my clients.						
My education/skills/abilities are used to their full potential at _____.						
The team leader should always be a physician.						
The team leader at _____ is always a physician.						
Nursing education in the following areas is important to do my job: Public health nursing Biostatistics Nursing research Health services administration Health policy mechanisms Primary health care principles Teamwork Community advocacy Health education principles Epidemiology Other (please list):						

The following factors affect whether RNs are able to provide the health care services they are capable of:	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Don't Know**
Personal characteristics of nurse (e.g. motivation)						
Nursing education						
Nursing experience						
Perception of role of nurses						
Professional legislation						
Types of clients						
Workload						
Client needs						
Client expectations						
Make-up of health care team						
Funding of program area						
Job description						
Employer policies						
Employer expectations						
Support from employer						
Support from professional association						
Other (please list):						

Physician Questionnaire

1. How long have you worked in community-based care? (Please check one)

   Less than 1-year ❒ 1-3 years ❒ 3-5 years ❒ 5-10 years ❒ 10-15 years ❒

   16 years or more ❒

2. How long have you worked at the _____? (Please check one)

   0-3 months ❒ 12-18 months ❒

   3-12 months ❒ 18-24 months ❒ More than 24 months ❒

Please indicate your level of agreement with following statements. If you have no opinion or don't wish to answer the question, please check "Don't know".	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Don't know**
The following roles are important for nurses in their role at _____:						
Resource planner						
Resource for clients						
Teacher of clients						
Teacher of other health care professionals						
Direct care provider						
Coordinator of client care						
Liaison with other community organizations						
Client advocate						
Team leader						
Team member						
Community developer						
Consultant to other health team members						
Facilitator of care for clients						
Evaluator of services provided by _____						
Health promoter						
Illness and injury prevention						
Policy developer						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know
The following attributes are important for nurses in their role at _____:						
Flexibility						
Accountability						
Self-directed						
Knowledge of primary health care						
Politically conscious						
Health (versus illness) oriented						
Socially aware						
Other (please list):						
Nurses at _____are involved in:						
Planning _____programs and services						
Implementing _____programs and services						
Evaluating _____programs and services						
Development of their job descriptions						
Planning education for clients						
Selecting clients for education						
Providing education sessions						
Other (please list):						
The education/skills/abilities of registered nurses at _____to their full potential.						
The team leader should always be a physician.						
The team leader at _____is always a physician.						
Nursing education in the following areas is important to perform their job at _____:						
Public health nursing						
Biostatistics						
Nursing research						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
Health services administration						
Health policy mechanisms						
Primary health care principles						
Teamwork						
Community advocacy						
Health education principles						
Epidemiology						
Other (please list):						
The following factors affect whether RNs are able to provide the health care services they are capable of:						
Personal characteristics of nurse (e.g. motivation)						
Nursing education						
Nursing experience						
Perception of role of nurses						
Professional legislation						
Types of clients						
Workload						
Client needs						
Client expectations						
Make-up of health care team						
Funding of program area						
Job description						
Employer policies						
Employer expectations						
Support from employer						
Support from professional association						
Other (please list)						

MANAGER QUESTIONNAIRE

1. What is your job title? _____

2. What educational preparation do you have? (Please check one)

   Diploma ❒ Baccalaureate ❒ _____(specify)

   Masters ❒ _____(specify) PhD ❒ _____(specify)

3. How long have you worked in community-based care? (Please check one)

   Less than 1-year ❒ 1-3 years ❒ 3-5 years ❒ 5-10 years ❒ 10-15 years ❒

   16 years or more ❒

4. How long have you worked as a manager?

   Less than 1-year ❒ 1-3 years ❒ 3-5 years ❒ 5-10 years ❒ 10-15 years ❒

   16 years or more ❒

5. How long have you worked at _____? (Please check one)

   0-3 months ❒ 12-18 months ❒

   3-12 months ❒ 18-24 months ❒ More than 24 months ❒

Please indicate your level of agreement with following statements. If you have no opinion or don't wish to answer the question, please check "Don't know".	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Don't know**
The following roles are important for nurses at _____:						
Resource planner						
Resource for clients						
Teacher of clients						
Teacher of other health care professionals						
Direct care provider						
Coordinator of client care						
Liaison with other community organizations						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know
Client advocate						
Team leader						
Team member						
Community developer						
Consultant to other health team members						
Facilitator of care for clients						
Evaluator of services provided by ESRDP						
Health promoter						
Illness and injury prevention						
Policy developer						
The following attributes are important for nurses at _____:						
Flexibility						
Accountability						
Self-directed						
Knowledge of primary health care						
Politically conscious						
Health (versus illness) oriented						
Socially aware						
Other (please list):						
In their roles as nurses at _____, nurses are/were involved in:						
Development of their job description						
Planning programs & services						
Implementing programs & services						
Evaluating programs & services						
Planning education for clients						
Providing education sessions						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know
Independently identifying needs for client education						
Selection of clients for education						
Planning the budget for ESRDP						
Other (please list):						
Nurses have input into decisions that affect their nursing practice.						
Nurses at _____are encouraged a role in addressing barriers to health such as poverty and unemployment.						
The education/skills/abilities of registered nurses at _____are used to their full potential						
The team leader should always be a physician.						
The team leader at _____is always a physician.						
Nursing education in the following areas is important to do their jobs at _____:						
Public health nursing						
Biostatistics						
Nursing research						
Health services administration						
Health policy mechanisms						
Primary health care principles						
Teamwork						
Community advocacy						
Health education principles						
Epidemiology						
Other (please list):						

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't know
The following factors affect whether RNs are able to provide the health care services they are capable of:						
Personal characteristics of nurse (e.g. motivation)						
Nursing education						
Nursing experience						
Perception of role of nurses						
Professional legislation						
Types of clients						
Workload						
Client needs						
Client expectations						
Make-up of health care team						
Funding of program area						
Job description						
Employer policies						
Employer expectations						
Support from employer						
Support from professional association						
Other (please list)						

APPENDIX F

INTERVIEW GUIDES

RN Interview Guide

(Probes are listed as reminders or cues for the interviewer; use of the probes will be determined by the answers of the participants). Inform participant of his/her right to stop or to not answer any question.

(1) Can you tell me about a typical day on the job?
Probe: What are some of the tasks/activities that you do?
What are you responsible for?

(2) Tell me about some of the things that you like about the nursing practice you provide here at _____.
Probe: Are there things that you can do here that you haven't been able to do in other places?

(3) What types of things make it easier to do the type of nursing care that you like to provide?

(4) Can you tell me about some of the challenges you face in providing nursing care?
Probe: What situations or factors make it difficult to practice the nursing care that you believe you should provide?
How do they make it difficult?
Are there times when you feel like your potential is not being used fully? (when and how)
Are there things in your job that you are asked to do that you do not feel are nursing activities?

(5) Do you have some thoughts about what the physicians and managers at the practice see as the role of nurses?

Manager Interview Guide

(Probes are listed as reminders or cues for the interviewer; use of the probes will be determined by the answers of the participants) Inform participant of his/her right to stop or to not answer any question.

(1) Can you tell me about what some of the important factors that you consider when hiring/evaluating nurses for the _____ program?

(2) What do you see as being the major role of registered nurses at _____?
Probe: what makes it important

(3) What are some of the major challenges for nurses at _____?

(4) How do you see the role of nurses evolving in the delivery of primary health services at _____?

Physician Interview Guide

(Probes are listed as reminders or cues for the interviewer; use of the probes will be determined by the answers of the participants)

Inform participant of his/her right to stop or to not answer any question.

(1) What do you see as being the major role of registered nurses at_____?
Probe: identification of areas of overlap/boundaries between physicians and nurses
major differences in roles between physicians and nurses
limits to what nurses should do

(2) Tell me about some of the things that you would like to see nurses at _____ doing that they currently aren't.
Probe: Why do you think that they aren't doing them?

(3) What are some of the major challenges for nurses at _____?

(4) Can you tell me about some of the things that make it easier for nurses to practice at _____?

Appendix G
Survey Results Table 3.12

The following roles are important for current nursing roles at the employer – agree and strongly agree:

Role	RNs			Managers			Doctors		
	N	n	%	N	n	%	N	n	%
Program planner	25	9	36.0	7	5	71.4	15	10	66.7
Resource for clients	27	27	100.0	7	7	100.0	16	16	100.0
Teacher of clients	27	27	100.0	7	7	100.0	16	16	100.0
Teacher of other health care professional.	27	19	70.4	7	6	85.7	16	13	81.3
Direct care provider	26	25	96.2	7	7	100.0	15	11	73.3
Coordinator of client care	27	23	85.2	7	7	100.0	15	11	73.3
Liaison with other community orgs	26	26	100.0	7	7	100.0	16	15	93.8
Client advocate	27	27	100.0	7	7	100.0	16	14	87.5
Team leader	26	14	53.8	7	4	57.1	16	9	56.3
Team member	27	27	100.0	7	7	100.0	16	15	93.8
Community developer	26	13	50.0	7	3	42.9	16	6	37.5
Consultant to other health care team members	27	23	85.2	7	7	100.0	16	16	100.0
Facilitator of care for clients	25	24	96.0	7	7	100.0	16	15	93.8
Evaluator of services provided by site	25	11	44.0	7	5	71.4	16	10	62.5
Health promoter	27	27	100.0	7	6	85.7	16	16	100.0
Illness and injury prevention	27	24	88.9	7	5	71.4	16	14	87.5
Policy developer	27	8	29.6	7	4	57.1	16	8	50.0

The following roles are important for current nursing roles at the employer – agree and strongly agree:

Role	RNs			Managers			Doctors		
	N	n	%	N	n	%	N	n	%
Program/resource planner	25	4	16.0	7	1	14.3	15	1	6.7
Resource for clients	27	0	0.0	7	0	0.0	16	0	0.0
Teacher of clients	27	0	0.0	7	0	0.0	16	0	0.0
Teacher of other health care prof.	27	1	3.7	7	0	0.0	16	0	0.0

Direct care provider	26	0	0.0	7	0	0.0	15	1	6.7
Coordinator of client care	27	1	3.7	7	0	0.0	15	1	6.7
Liaison with other community orgs	26	0	0.0	7	0	0.0	16	0	0.0
Client advocate	27	0	0.0	7	0	0.0	16	0	0.0
Team leader	26	3	11.5	7	1	14.3	16	1	0.0
Team member	27	0	0.0	7	0	0.0	16	0	0.0
Community developer	26	8	30.7	7	2	28.6	16	2	12.6
Consultant to other health care team members	27	0	0.0	7	0	0.0	16	0	0.0
Facilitator of care for clients	25	0	0.0	7	0	0.0	16	0	0.0
Evaluator of services provident by site	25	3	12.0	7	1	14.3	16	2	12.5
Health promoter	27	0	0.0	7	1	14.3	16	0	0.0
Illness and injury prevention	27	0	0.0	7	0	0.0	16	1	6.3
Policy developer	27	8	29.6	7	2	28.6	16	1	6.3

APPENDIX H

Survey Results of Nurse Attributes

Flexibility is important in for nurses

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	Percent	n	Percent	n	Percent
RNs (N=27)	26	96.3	1	3.7	0	0
Managers (N=7)	7	100	0	0	0	0
Physicians (N=16)	15	93.8	1	6.3	0	0

Accountability is important for nurses

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	Percent	n	Percent	n	Percent
RNs (N=27)	27	100	0	0	0	0
Managers (N=7)	7	100	0	0	0	0
Physicians (N=16)	15	93.8	1	6.3	0	0

Being self directed is important

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	Percent	n	Percent	n	Percent
RNs (N=27)	27	100	0	0	0	0
Managers (N=7)	6	85.7	1	14.3	0	0
Physicians (N=16)	16	100	0	0	0	0

Knowledge of primary health care is important

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	Percent	n	Percent	n	Percent
RNs (N=27)	25	92.6	2	7.4	0	0
Managers (N=7)	7	100	0	0	0	0
Physicians(N=16)	15	93.8	1	6.3	0	0

Being politically conscious is important

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	Percent	n	Percent	n	Percent
RNs (N=27)	15	55.6	12	44.4	0	0
Managers (N=7)	6	85.7	0	0	0	0
Physicians (N=16)	4	25.0	10	62.5	2	12.5

Having a health versus illness orientation is important

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	Percent	n	Percent	n	Percent
RNs (N=27)	25	92.6	2	7.4	0	0
Managers (N=7)	6	85.7	1	14.3	0	0
Physicians (N=16)	13	81.3	3	18.8	0	0

Being Socially Aware is Important

Stakeholder Group	Strongly Agree/Agree		Neutral/Don't Know		Strongly Disagree/Disagree	
	n	Percent	n	Percent	n	Percent
RNs (N=26)	23	85.2	3	11.1	0	0
Managers (N=7)	6	85.7	1	14.3	0	0
Physicians(N=15)	11	73.3	4	25.0	0	0

APPENDIX I

SUMMARY OF TWO NURSING MODELS

A. The Allen Nursing Model (McGill Model)

The McGill Model which originated in community care was developed over the span of two decades by Dr. Moyra Allen at McGill University in Montreal and is used in a number of health care educational institutions and organizations across Canada (Gaudine, 2001; Kravitz and Frey, 1989).

The major belief underlying the McGill Model is that the "health of a nation is its most valuable resource" (Gottlieb and Rowat, 1987, p. 53). The Model also assumes that "individuals, families, and communities do indeed aspire to and are motivated toward better health. Furthermore, there resides within these persons the potential to develop and achieve this end. A third assumption is that health is best learned through active involvement and personal discovery". Allen also believes that "health is a phenomenon of the family …[and] nursing is a primary health resource for families and communities" (in Kravitz and Frey, 1989, p. 318).

The McGill Model focuses nursing on the development and maintenance of "family health, where health includes the ability to cope, learn new ways of problem solving, and to develop over time" (Gaudine, 2001, p. 77). The definition of environment as the context in which health is learned is intrinsically linked with the definition of Person, or the unit of concern, as the family since health is also learned within the family context (Gottlieb and Rowat, 1987, p. 55-56).

In the McGill Model, nurses practice Situation-Responsive Nursing wherein health promotion is the "focus of nursing, the family [is] the unit of concern, learning [is]

the primary process for client and nurse, and collaboration [is] the cornerstone of the nurse-client relationship" (Kravitz and Frey, 1989, p. 320).

B. The Prince Edward Conceptual Model for Nursing (PEI Model)

The PEI Model was developed in 2000 to fill a gap left by the lack of new nursing models incorporating primary health care principles. In the Model, primary health care is seen as "both a philosophy and a delivery method of care" (Munro, 2000, p. 40). The PEI Model is similar to other existing nursing models in that all define the concepts of person, health, environment and nursing within the models. However, underlying the PEI Model are several assumptions including that "clients have the potential to become active participants in problem-solving on behalf of themselves or others…clients are partners in their own health care….[and] health is a political process" (Barnes et al, 2000, p. 42). The PEI Model gives importance to the sociopolitical facts that affect the health of individuals, families, groups, or communities" (Barnes et al, 2000, p. 43).

The goal of nursing practice is the promotion of wellness and the prevention of illness through partnership with the person/client; the environment is seen as the internal and external context of every aspect of life; health is defined as a dynamic process incorporating wellness and illness wherein health is determined by social, political and economic factors; and the person is defined as individual, family, group or community (Barnes et al, 2000, p. 41-46).

One significant departure from previous nursing models is that in the PEI Model, nurses are "challenged to think 'upstream' about the social, political, and economic factors that contribute to a health concern…[and] identifies potential wellness collaborators both within and outside the health sector" (Barnes et al., 2000, p. 49).